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Supreme Court of the United States

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA AND BOARD OF TRUSTEES OF CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA,
Petitioners,

vs.

RAYMOND STONE,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. May the fiduciaries of an ERISA-regulated health plan bring an action against a plan participant under Section 502(a)(3) of ERISA, 29 U.S.C. Section 1132(a)(3), to compel the participant to reimburse medical expenses advanced by the plan, as required by the plan's governing instrument and by a written reimbursement agreement between the plan and the participant?

2. Does Section 502(a)(3) of ERISA, 29 U.S.C. Section 1132(a)(3), which permits fiduciaries to seek only "appropriate equitable relief," bar a claim by fiduciaries of an ERISA-regulated plan for restitution or reimbursement of medical costs advanced to a plan participant?

3. Does the limitation of Section 502(a)(3) of ERISA to recovery of only "appropriate equitable relief" preclude claims seeking specific performance, injunctive relief, restitution or other traditional equitable remedies, merely because the grant of such equitable relief will result in a monetary recovery by an ERISA-regulated trust?

4. Does an equitable action for restitution lie only when the sums sought to be recovered are "ill-gotten gains" obtained through fraudulent or dishonest means?

LIST OF PARTIES TO THE PROCEEDING

Petitioners are Cement Masons Health and Welfare Trust Fund For Northern California and Board Of Trustees Of Cement Masons Health And Welfare Trust Fund For Northern California. The individual trustees are Ohnie Oakley, Edward T. Bergo, Thomas R. Estrada, George R. Wilson, Derrel Hardy, Karl Bik, Steven Scott and Catherine Escobar.

Respondent is Raymond Stone, an individual.

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PETITION FOR WRIT OF CERTIORARI

Petitioners Cement Masons Health and Welfare Trust Fund For Northern California and Board of Trustees of Cement Masons Health and Welfare Trust Fund For Northern California respectfully pray that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Ninth Circuit entered in this proceeding on December 9, 1999.

I.

OPINIONS BELOW

The opinion of the U.S. Court of Appeals for the Ninth Circuit (Appendix A herein) is reported at 197 F.3d 1003. The Memorandum and Order of the U.S. District Court for the Eastern District of California (Appendix B herein) filed June 2, 1998, is not reported.

II.

JURISDICTION

The jurisdiction of this Court is invoked pursuant to the provisions of 28 U.S.C. Section 1254(1). The opinion of the U.S. Court of Appeals for the Ninth Circuit was filed on December 9, 1999; this Petition is timely filed with this Court under the provisions of 28 U.S.C. Section 2101(c).

III.

STATUTORY PROVISIONS INVOLVED

The statutory provisions involved in this action are Section 514(a) and Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1144(a) and 1132(a)(3). The statutory provisions are set forth in Appendix C.

IV.

STATEMENT OF THE CASE

This action was brought by the Cement Masons Health and Welfare Trust Fund For Northern California ("CMHWT") and the Board of Trustees of the Cement Masons Health and Welfare Trust Fund For Northern California ("Trustees") to recover funds advanced to defray medical expenses incurred by Kimberly Stone, a now-deceased CMHWT participant; the CMHWT paid $572,325.80 in medical expenses on Ms. Stone's behalf. The suit sought restitution of funds advanced pursuant to a written reimbursement agreement and pursuant to the terms of the CMHWT plan itself, from funds recovered by Kimberly Stone's surviving spouse, Raymond Stone ("Stone"), and the Stones' dependent children. The terms of the CMHWT plan and the reimbursement agreement do not require the mere payment of money, but also require Stone, and his dependents, to take specific steps to attempt to recover medical expenses from third parties responsible for Kimberly Stone's injuries, and to keep the plaintiffs advised of such efforts. (See discussion, *infra*)

The CMHWT is an employee benefit trust fund established pursuant to a declaration of trust executed by employer associations representing employers in the unionized construction industry and union representatives of the District Council of Plasterers and Cement Masons of Northern California. Pursuant to the provisions of the declaration of trust, the CMHWT is governed by a Board of Trustees consisting of an equal number of employer and union representatives. The CMHWT trustees are empowered to promulgate, and have promulgated, a health and welfare plan for the benefit of covered participants and their eligible dependents. The plan provides, *inter alia*, medical, hospitalization and other benefits to covered participants and their eligible dependents. The parties agree that the CMHWT is an ERISA-regulated entity.

The CMHWT plan requires restitution and reimbursement of monies when a participant or eligible dependent makes a recovery from a third party source. Article IX, Section 9 of the CMHW Plan provides:

> "If an eligible individual has an ... illness, injury or condition ... for which a third party may be liable or legally responsible ... the Fund *shall have an automatic* lien upon any recovery against the third party for benefits paid by the Fund ... and such Eligible Individual *and his Dependents* ... as a condition precedent to the entitlement

> to benefits *shall agree in writing* to reimburse the Fund for any payments made by the Fund ... such reimbursement to be made out of any proceeds received by way of judgment, settlement or otherwise in connection with or arising out of any claim for or right to damages by such Eligible Individual against the third party, his insurance carrier ... or any other source of third party recovery. ... The agreement shall require *the Eligible Individual and his Dependents*, if any, *to prosecute such claim for damages diligently; to give priority to the reimbursement of the Fund in the allocation of the proceeds of any recovery; to cooperate and assist the Fund in obtaining reimbursement for such payments; to execute any documents necessary to secure such reimbursement; and to refrain from any act or omission which might hinder such reimbursement. ...*" [Emphasis supplied]

Raymond Stone, decedent Kimberly Stone's husband, is a CMHWT participant. Raymond Stone executed a reimbursement agreement on January 17, 1996, which recites, in pertinent part:

> "The undersigned Participant has submitted to the Cement Masons Health and Welfare Trust Fund for Northern California, a claim for benefits

in connection with an illness, injury, disease or other condition for which a third party may be liable or legally responsible by reason of an act or omission of such third party. Therefore, pursuant to Section 9 of Article IX of the Fund's Health and Welfare Plan and as a condition precedent to his entitlement to benefits from the Fund, the undersigned agrees to reimburse the Fund for any payments made by the Fund on account of hospital, medical or other expenses in connection with, or arising out of, any such injury, illness, disease or other condition, such reimbursement to be made out of any proceeds received by way of judgement, arbitration award, settlement or otherwise in connection with, or arising out of, any claim for or right to damages *by the undersigned or his Dependent* against such third party, his insurance carrier, guarantor or other indemnitor, or by reason of uninsured or under-insured motorist coverage of *the undersigned or his Dependent*, or any other source of third party recovery.

"The undersigned hereby further agrees that *the undersigned and his Dependent*, if any, *will prosecute such claim for damages diligently; will cooperate and assist the Fund in*

> *obtaining reimbursement for such payments; will give priority to the reimbursement of the Fund in the allocation of the proceeds of any recovery; will execute any documents necessary to confirm or establish a lien in favor of the Fund on any such claim, action or recovery of damages or to otherwise secure such reimbursement;* and will refrain from any act or omission that might prejudice or hinder such reimbursement." [Emphasis supplied]

The CMHWT's complaint alleged that defendant Raymond Stone and his dependents "have pursued and are pursuing claims against the party or parties who caused the accident in which Kimberly Stone sustained injuries, and the allegedly negligent health care provider" and further alleged that Stone "(1) has failed to acknowledge the right of plaintiffs to assert their lien for reimbursement against sums recovered or to be recovered from third parties; (2) has failed to advise plaintiffs of the status of his claims against the third party; and (3) has, on information and belief, taken steps to insulate the recovery of defendant and his dependents from the lien of plaintiffs." Plaintiffs further alleged that defendant Stone's conduct "violates the terms of the CMHWT plan" and "violates the terms of the reimbursement

agreement."[1] The Complaint alleged that the trustees "have no legal remedy at law, and therefore request a declaratory judgment and an injunctive order finding and requiring defendant to (1) acknowledge the lien of the CMHWT on any proceeds recovered from third parties up to and including $572,325.80, plus interest thereon; (2) requiring defendant to fully advise plaintiffs of the nature and status of all claims against third parties for recovery of expenses and/or damages in connection with the injuries and death of Kimberly Stone; and (3) to refrain from obstructing plaintiffs' right to enforce their lien against any proceeds recovered by defendant and his dependents from third parties."

Stone answered the Complaint; in his answer "defendant Stone [admitted] that he and his dependents have pursued and are pursuing claims against the parties who caused the accident in which Kimberly Stone sustained injuries, and the negligent health care providers, [but] defendant Stone does not acknowledge the plaintiffs' right to assert their lien for reimbursement against sums recovered from third parties." Stone's answer alleged as an affirmative defense that "Plaintiff is not entitled to seek recovery on its alleged lien and is barred from the recovery currently sought pursuant to *Pacificare v. Martin*, 34

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[1]Stone's successful motion for summary judgment, described below, was predicated on the assumption that there are no material facts in dispute; "he chose to accept as true all of plaintiffs' allegations in the complaint." *Stone*, 197 F.3d at 1008.

F.3d 834 (9th Cir. 1994)." Stone filed a motion for summary judgment on April 15, 1998 which was heard and orally granted on May 29, 1998.

The trial court's brief Memorandum and Order, filed June 2, 1998, states: "Stone argues that plaintiffs' suit seeks reimbursement, not restitution within the meaning of § 1132(a)(3), and that the court lacks subject matter jurisdiction over plaintiff's claim for reimbursement. The court agrees. Stone's motion for summary judgment is granted." (Memorandum and Order, p. 2, ll. 5-7)

The sole basis for the trial court's ruling was the decision of the Ninth Circuit in *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1261 (9th Cir. 1997), which held that this Court's decision in *Mertens v. Hewitt Associates*, 508 U.S. 248, 113 S.Ct. 2063 (1993), foreclosed any action under Section 1132(a)(3) of ERISA for "monetary relief." (Memorandum and Order, p. 2)

The U.S. Court of Appeals for the Ninth Circuit affirmed in pertinent part, finding that *FMC Medical Plan, supra*, is "legally indistinguishable" from the present case and compels dismissal.[2] 197 F.3d at 1006. The panel reversed the trial court on one point. The trial court had dismissed the action for lack of jurisdiction. The panel held that jurisdiction existed, but that ERISA provided no remedy. Therefore, the

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[2]Although *Owens* is contrary to holdings in other circuits, the plaintiff medical plan in *Owens* did not petition this court for a writ of certiorari.

panel ruled dismissal should have been on the merits. 197 F.3d at 1007-08. The panel remanded to the U.S. District Court with instructions to dismiss the case on the merits.[3] 197 F.3d at 1008.

In affirming the trial court, the circuit panel rejected the argument that a claim of restitution would lie against Raymond Stone; the panel held that an action in restitution is only appropriate where the claimant is seeking to recapture "ill-gotten gains." 197 F.3d at 1006-07, citing *Owens*, 122 F.3d at 1261. The panel stated that "we have construed ill-gotten gains to mean money obtained through 'fraud or wrongdoing ...'" and found that Stone's refusal to honor his reimbursement agreement and plan reimbursement requirements did not cause his "gain" of over half a million dollars to be "ill-gotten." 197 F.3d at 1007.

The panel also ruled that the fiduciaries' claims for declaratory and injunctive relief were not tenable because they were merely a mechanism "to obtain the equivalent of a damage remedy." *Id.*

Finally, the panel ruled that the only fund at issue was $50,000 recovered by the Stones' two minor children who "have no obligation whatsoever under

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[3]Although the panel held itself bound to follow *Owens*, *Owens* dismissed the claimant's reimbursement suit for lack of subject matter jurisdiction, *not* on the merits. See *Owens*, 122 F.3d at 1261.

the plan appellants' are seeking to enforce."[4] 197 F.3d at 1007. The panel acknowledged the fiduciaries' contention that "Mr. Stone attempted to circumvent his obligation by allowing his children to exhaust the [insurance] policy limits with their claims ... [and] Mr. Stone dismissed his own claims in [a] second lawsuit to prevent the fund from sharing in any recovery resulting from the wrongful death claim."[5] 197 F.3d at 1005. But the panel failed to discuss the implications of these undisputed points in the record.

On remand, the trial court dismissed the case on the merits.

Petitioners timely filed the within petition.

V.

REASONS THE PETITION SHOULD BE GRANTED

A. The Ninth Circuit's Decision Is in Direct Conflict with Decisions from the Seventh, Eighth and Eleventh Circuits

As noted above, the panel opinion relies entirely on the earlier circuit decision in *FMC Medical Plan v.*

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[4]This is an erroneous statement. Both the CMHWT Plan and the reimbursement agreement obligate "dependents" to take steps to reimburse the trust for medical costs advanced.

[5]In fact, it appears that Mr. Stone a rranged for a third party to serve as guardian ad litem for the children, precisely to avoid the terms of the plan and the reimbursement agreement.

Owens, 122 F.3d 1258, 1261-62 (9th Cir. 1997). The panel opinion fails to discuss or even acknowledge the reported cases from the Seventh, Eighth and Eleventh Circuits which reject the reasoning of *Owens*; see *Administrative Committee v. Gauf*, 188 F.3d 767 (7th Cir. 1999); *Southern Council of Industrial Workers v. Ford*, 83 F.3d 966 (8th Cir. 1996); *Blue Cross and Blue Shield of Alabama v. Sanders*, 138 F.3d 1347 (11th Cir. 1998).[6]

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[6]There is, in fact, an *intra-circuit* conflict on the question of whether "appropriate equitable relief" may include a specific performance action to compel reimbursement of medical expenses advanced by an ERISA-regulated trust fund. As noted above, the Ninth Circuit's published opinion in *FMC Medical Plan v. Owens, supra*, held that "equitable relief" did not permit a claim for restitution to lie against a plan participant that had signed a reimbursement agreement, because the ultimate object of the suit was to compel reimbursement of monies paid to a plan participant, which the court characterized as "monetary damages:" 122 F.3d at 1261. But the same court previously permitted a suit to compel reimbursement on an unjust enrichment theory to proceed; see *Chitkin v. Lincoln National Insurance Co.*. 15 F.3d 1083 (9th Cir. 1994) [unpublished], printed as an appendix in *Chitkin v. Lincoln National Insurance Co.*, 879 F.Supp. 841, 864 (S.D. Cal. 1995). In yet another Ninth Circuit decision, a concurring member of the panel stated flatly that "money damages are available under Section 502(a)(3) as a form of restitution ...." *Farr v. U.S. West Communications, Inc.*, 151 F.3d 908, 917 (per Hawkins, C.J.), amended by *Farr v. U.S. West Communications, Inc.*, 179 F.3d 1252 (9th Cir. 1999), *cert. denied*, ____ U.S. ____, 68 USLW 3291, 3355 (Jan. 18, 2000) . Although these cases were cited in petitioners' briefs, the circuit panel failed to acknowledge or discuss any of them.

The *Gauf* decision is virtually on all fours with *Stone* and *Owens*. The Wal-Mart Associates Health & Welfare Plan ("Plan") sued Wal-Mart employee Patricia Gauf to compel reimbursement of $9,870 in benefits, pursuant to a Plan provision requiring reimbursement when employees obtain a tort recovery for damages arising out of the medical condition for which the Plan paid; 188 F.3d at 768-69. As in the present case, the Plan sued under Section 502(a)(3) of ERISA to obtain "other appropriate equitable relief ... to enforce ... the terms of the Plan." Gauf's attorneys argued that the Plan was seeking a legal remedy, because the ultimate purpose of the suit was to obtain reimbursement of money; 188 F.3d at 770. The Seventh Circuit rejected this argument stating:

> "Although the pertinent parts of the complaint employ a variety of terms to express the relief requested, we believe that a fair reading of the document in its totality makes clear that the Committee is seeking an equitable remedy against Ms. Gauf to insure her compliance with the terms of the Plan. For example, the complaint requests 'specific performance and enforcement' of the contract and an 'order enjoining defendant from continuing to violate the terms of the Plan."

Gauf acknowledged the *Owens* decision and rejected it, noting that "our Circuit consistently has held that a complaint purporting to state a claim for equitable

relief under a reimbursement clause in a benefits contract is an equitable claim for purposes of ERISA Section 502(a)(3)." 188 F.3d at 771, citing *Harris Trust & Savings Bank v. Provident Life & Accident Ins. Co.*, 57 F.3d 608, 615 (7th Cir. 1995); *Central States, Southeast and Southwest Areas Health & Welfare Fund v. Neurobehavioral Associates*, 53 F.3d 172, 173-74 (7th Cir. 1995).

Blue Cross and Blue Shield of Alabama v. Sanders, 138 F.3d 1347 (11th Cir. 1998), is yet another case in which a health plan was permitted to pursue a claim for equitable relief to compel reimbursement under Section 502(a)(3) of ERISA. As in *Owens*, *Gauf* and the present case, the action arose out of plan provisions permitting the plan to obtain reimbursement in the event the participant obtained a tort recovery against a party causing the injury for which benefits were paid. As in *Gauf* and the present action, the defendants relied on *Owens'* assertion that a reimbursement claim is an action for legal relief unavailable under Section 502(a)(3) of ERISA. The Eleventh Circuit squarely rejected this argument stating that "*Owens* appears to be based on an unduly narrow reading of *Mertens v. Hewitt Associates*, 508 U.S. 248, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993).[7] ... The Court in *Mertens* did not imply

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[7]*FMC Medical Plan v. Owens, supra*, has been the subject of some critical legal commentary; see *Lawrence and Russell*, "Substantive and Procedural Considerations in Initiating a Recoupment Action Under ERISA Section 502(a)(3),", 34 Tort & Insurance Law Journal, 970, 977 (1999).

that specific performance is unavailable under 29 U.S.C. § 1132(a)(3)(B). Because specific performance is a traditional form of equitable relief, see *Owens-Illinois, Inc. v. Lakeshore Land Co., Inc.*, 610 F.2d 1185, 1189 ... we believe that specific performance may be equitable relief available under 29 U.S.C. § 1132(a)(3)(B)." 138 F.3d at 1352-1353, n. 5. See also *In re Unisys Corp. Retiree Medical Benefit ERISA Litigation*, 57 F.3d 1255, 1268-69 (3rd Cir. 1995) [equitable relief under Section 1132(a)(3)(B) includes monetary awards typically available in equity, but not compensatory or consequential damages].

The present case is legally indistinguishable from *Gauf* and *Sanders*. Only the Ninth Circuit's precedential decision in *Owens*, which appears not to have been followed by any other circuit, defeated the CMHWT's claim.

On slightly different facts, the appellate court in *Southern Council of Industrial Workers v. Ford*, 83 F.3d 966 (8th Cir. 1996), upheld the right of a plan administrator to sue to enforce subrogation provisions and a written subrogation agreement;[8] the action, which was for specific performance, sought to compel a plan participant to reimburse the plan for

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[8]Under the rationale of the panel opinion below and of *Owens*, it makes no practical difference whether the Plan is suing to enforce a subrogation agreement or a reimbursement agreement. In either case, the argument is that the action will ultimately result in a monetary recovery to the fund, and that such a monetary recovery is precluded by the limitation of Section 502(a)(3) of ERISA to recovery of "appropriate equitable relief."

medical expenses previously advanced, out of proceeds gained from settlement of a personal injury claim against a supermarket. Noting that the allegation "that Ford admittedly failed to reimburse is a claim that Ford failed to comply with a term of the Plan," the court found that the Plan's equitable action for unjust enrichment would lie under Section 502(a)(3) of ERISA. 83 F.3d at 969. Other courts have permitted equitable actions for restitution or other equitable relief to proceed without any extended analysis of whether the "appropriate equitable relief" rubric of Section 502(a)(3) limited such rights; see, e.g., *Health Cost Control v. Isbell*, 139 F.3d 1070 (6th Cir. 1997); *LeBlanc v. Cahill*, 153 F.3d 134 (4th Cir. 1998); *Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938 (5th Cir. 1998); *United McGill Corp. v. Stinnett*, 154 F.3d 168 (4th Cir. 1998).[9]

This Court should grant certiorari to resolve the conflict among the circuits and provide clear guidance about the limits of "appropriate equitable relief" under Section 502(a)(3)(B) and under *Mertens*.[10]

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[9]In *Walker v. Rose*, 22 F.Supp.2d 343 (D. N.J. 1998), the trial court permitted the plaintiff to proceed with a reimbursement claim on behalf of an ERISA-regulated plan stating that "plaintiff's amended complaint does not seek monetary damages, but instead seeks to enforce the plan's subrogation/reimbursement provision, a remedy which is restitutionary in nature ...." 22 F.Supp. at 349-50.

[10]This at least the seventh time that the Ninth Circuit has visited the question, in many different factual contexts, of what

(continued)

B. The Court Should Grant Certiorari to Clarify the Meaning of its Holding in *Mertens*

In *Mertens v. Hewitt Associates*, 508 U.S. 248, 113 S.Ct. 2063 (1993), this Court ruled that an action for compensatory damages would not lie against a non-fiduciary under Section 502(a)(3) of ERISA for its knowing participation in the breach of a fiduciary duty imposed by ERISA. The petitioners represented a class of former employees of Kaiser Steel Corporation who participated in the Kaiser Steel Retirement Plan ("Plan"); the defendant, Hewitt Associates, was the Plan's actuary at a time when Kaiser was phasing out many operations, which made existing Plan actuarial assumptions obsolete. Because Hewitt Associates did not change the

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(fn. continued)
restrictions the phrase "appropriate equitable relief" places on the ability of a party mentioned in Section 502(a)(3) to obtain a meaningful remedy under ERISA; see *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1261 (9th Cir. 1997); *McLeod v. Oregon Lithoprint, Inc.*, 46 F.3d 956, 960 (9th Cir. 1995), *on remand* 102 F.3d 367 (1996); *Waller v. Blue Cross of California*, 32 F.3d 1337, 1339 (9th Cir. 1994); *Bast v. Prudential Insurance Co. of America*, 150 F.3d 1003 (9th Cir. 1998); *Farr v. U.S. West Communications, Inc.*, 151 F.3d 908 (9th Cir. 1998) *amended by Farr v. U.S. West Communications, Inc.*, 179 F.3d 1252 (9th Cir. 1999), *cert. denied*, ____ U.S. ____, 68 USLW 3291, 3355 (Jan. 18, 2000); and see *Chitkin v. Lincoln National Ins. Company*, 879 F.Supp. 841, 864-67 (S.D. Cal. 1995), publishing (as an appendix) the circuit's (previously unpublished) opinion cited at 15 F.3d 1083 (1994). Only a ruling from this court will end the long dialogue about the meaning of the term "appropriate equitable relief" in Section 502(a)(3).

actuarial assumptions, Kaiser did not adequately fund the Plan, and Plan assets became insufficient to satisfy benefit obligations. 508 U.S. at 250-51. This Court found that Section 502(a)(3) would not support a claim against Hewitt, a non-fiduciary, to compel Hewitt to restore the Plan's losses, because "although we often dance around the word, what petitioners in fact seek is nothing other than compensatory damages — monetary relief for all losses their Plan sustained as a result of the alleged breach of fiduciary duties." 508 U.S. at 255.

In contrast to the present case, and the reimbursement cases discussed in Part V.A. of this petition, this Court in *Mertens* specifically noted that "no one suggests that any term of the Kaiser Plan has been violated, nor would any be enforced by the requested judgment." 508 U.S. at 253.

Moreover, this Court in *Mertens* did not bar equitable remedies which would ultimately result in a monetary recovery. The Court's opinion notes that the petitioners did not "seek a remedy traditionally viewed as 'equitable,' such as injunction or restitution." 508 U.S. at 256. Noting that "restitution" was among "those categories of relief that were typically available in equity ..." this Court went on to say "'equitable' relief must mean something less than all relief." But this Court did not say that the "less than all relief" mandated by Section 502(a)(3) of ERISA would exclude any equitable action ultimately resulting in a monetary recovery. Indeed, monetary recoveries are commonplace in restitutionary actions. See, e.g.,

Schwartz v. Gregori, 45 F.3d 1017 (6th Cir. 1995). Understandably, this Court declined to define the outer limits of "appropriate equitable relief" which could be obtained under Section 502(a)(3).

The assertion in the panel's opinion and in *Owens* that *Mertens* precludes any equitable relief which ultimately results in the payment of money goes far beyond the language of *Mertens* itself. Indeed, *Mertens explicitly analogizes* the phrase "other appropriate equitable relief" to "the similar language of Title VII of the Civil Rights Act of 1964" which includes the term "any other equitable relief the court deems appropriate ...." *Mertens*, *supra*, 508 U.S. 248, 255, 113 S.Ct. at 2068. No one would dispute that Title VII authorizes equitable relief which includes the payment of money; for example, the Supreme Court has authorized awards of both back pay and front pay (both monetary remedies) under Title VII, with no evident doubt that such payments constitute "equitable relief." See, e.g., *Albermarle Paper Co. v. Moody*, 422 U.S. 405, 95 S.Ct. 2362 (1975). Section 706(g) of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-5(g), permits a court to require "reinstatement or hiring of employees *with or without back pay* [parenthetical omitted] or *any other equitable relief* as a court may deem appropriate ...." [Emphasis supplied] See also *Schwartz v. Gregori*, 45 F.3d 1017 (6th Cir. 1995) ["... the backpay awarded here constituted restitution and therefore is an equitable remedy under § 502(a)(3)." 45 F.3d at 1023]; *Roush v. KFC Nat'l. Management Co.*, 10 F.3d at 392, 398 (6th Cir. 1993), *cert. denied*, ____ U.S.

____, 115 S.Ct. 56 (1995) [front pay characterized as equitable].

It is obvious that *Mertens* does not control this case. First, as noted above, in this case there *is* an attempt to use equitable remedies to enforce provisions of an ERISA-regulated plan. Second, the plaintiffs in *Mertens* were not seeking restitution or reimbursement as here, but compensatory damages. The only question on which certiorari was granted in *Mertens* was "whether ERISA authorizes suits for money damages against non-fiduciaries who knowingly participate in a fiduciary's breach of fiduciary duty." *Mertens, supra,* 508 U.S. at 251. Nevertheless, despite the obvious distinctions between this case and the reimbursement cases, the Ninth Circuit opinions in *FMC Medical Plan v. Owens,* 122 F.3d 1258 (1997), and in this suit rely on *Mertens* as authority for the proposition that no action will lie under Section 502(a)(3) to compel compliance with the Plan's reimbursement requirements.

Owens and the Ninth Circuit panel in this case take a very different view of *Mertens* from that expressed by the Seventh Circuit in *Administrative Committee v. Gauf,* 188 F.3d 767 (1999), and by the Eleventh Circuit in *Blue Cross and Blue Shield of Alabama v. Sanders,* 138 F.3d 1347 (1998).

Petitioners believe the narrow and crabbed reading of *Mertens* in *Owens* and the present case is not justified by either the facts or the language of *Mertens.* Nevertheless, because the court below has

spoken in two published opinions about the matter, reimbursement requirements of ERISA-regulated trust funds are unenforceable nullities in the nine states in which Ninth Circuit law controls.

C. Petitioners Properly Stated a Claim for Restitution in the Trial Court

In sole reliance upon *FMC Medical Plan v. Owens*, *supra*, the Circuit panel held that petitioners' claim could not be characterized as restitutionary because "restitution is referred to in *Mertens* as the return of 'ill-gotten' assets or profits from a plan." *Stone*, 197 F.3d at 1007, citing *Mertens*, 508 U.S. at 260, 113 S.Ct. at 2071. Petitioners submit that the *Owens* and *Stone* panels read far too much into the passing reference to "ill-gotten" assets in *Mertens*. *Mertens* does not say that restitution is *limited* to actions to recover "ill-gotten plan assets or profits," it uses the phrase only to give an *example* of a claim for equitable relief. *Id.*

The panel below relied on this reasoning in *Owens*:

> "Owens did not obtain FMC's funds by any fraud or wrongdoing. Owens obtained the funds pursuant to the Plans, which obligated the funds to be paid to him under the circumstances of the case. FMC's claim is for reimbursement of money that Owens rightfully received under the Plans." 122 F.3d at 1261.

With all due respect to the panel's decision in this case and to the previous panel's decision in *Owens*,

this reasoning is simply incorrect. Assuming that Stone and Owens each received money from the Plans *with no intention whatsoever* of honoring their reimbursement agreements or Plan reimbursement requirements, their receipt and retention of Plan monies would, indeed, be "ill-gotten" gains. Moreover, the intent of Stone at the time the funds were received is a question of fact, which simply cannot be resolved on a motion for summary judgment. It is baffling that the circuit panel found it self-evident that there is no way that Owens' and Stone's receipt of funds amounting to a double recovery could be characterized as an ill-gotten gain.

There is a substantial body of academic commentary which rejects the notion that wrongdoing is a necessary element of restitution:

> "Neither wrongdoing nor title is an essential element of a restitution claim. Restitution is an alternative remedy for an ordinary breach of contract with no wrongdoing and no title involved." *Dobbs*, Law of Remedies (2nd Ed., Section 4.1(2))

Professor Dobbs' statement is consistent with the *Restatement, Restitution* (ALI, 1937) which identifies "unjust enrichment" as the touchstone for entitlement to restitutionary relief. ["A person who has been unjustly enriched at the expense of another is required to make restitution to the other." *Restatement* § 1] Comment c to Section 1 of the *Restatement* seems clearly to apply here: "Even where a person has received a benefit from another

he is liable to pay therefore only *if the circumstances of its receipt or retention are such that, as between the two persons, it is unjust for him to retain it.*" [Emphasis supplied] Contemporary commentary is in accord: "Defendant may be unjustly enriched without having committed any other civil wrong." Haycock, "The Scope and Significance of Restitution," 67 Tex.L. Rev. 1277, 1284 (1989).

A far more complete statement and analysis of the law of restitution than is provided by *Owens* or the panel below is set forth in the Seventh Circuit's opinion in *Harris Trust & Savings v. Provident Life & Acc. Ins. Co.*, 57 F.3d 608, 615 (1995), a decision neither discussed nor acknowledged in *Owens* or in the panel opinion. *Provident Life* upheld the enforcement of a reimbursement agreement strikingly similar to that at issue in this case, and found that a cause of action for restitution would lie to compel enforcement; the court also held that a claim for unjust enrichment would lie, stating as follows:

> "Campbell sought to recover the amounts which had been advanced on Sandra's behalf on two theories. In Count I of its counterclaim, Campbell sought equitable relief in the form of restitution to enforce the third party exclusion and its reimbursement provision under 29 U.S.C. § 1132(a)(3). Alternatively, Court II purported to state an independent cause of action under the federal common law of unjust

enrichment which was recognized in *Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985 (4th Cir.), *cert. denied*, 498 U.S. 982, 111 S.Ct. 512, 112 L.Ed.2d 524 (1990). The district court appears to have proceeded under the second theory, holding that 'although ERISA did not provide a cause of action for an insurer to recover advances, reimbursement was necessary to prevent unjust enrichment.' *Harris Trust & Savings v. Provident Life and Acc. Ins. Co.*, 854 F.Supp. 524, 533 (N.D. Ill. 1994). We need not decide which of the two theories is applicable in the present case, however, for they are interrelated and *Campbell would prevail under either.*

> "29 U.S.C. §1132(a)(3) expressly provides that: A civil action may be brought --
>
> (3) by a participant, beneficiary, or *fiduciary* (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain *other appropriate relief* (i) to redress such violations or (ii) to enforce any

> provisions of this subchapter or the terms of the plan.

"Campbell has clearly stated a viable claim for relief under § 1132(a)(3)(B). It is a fiduciary within the meaning of ERISA; the Plan specifically provides for repayment of benefits advanced under the third party exclusion; Campbell's action was initiated to enforce the repayment provision; and Campbell sought 'appropriate equitable relief' in the form of restitution. See *Mertens v. Hewitt Assoc.*, ____ U.S. ____, ____, 113 S.Ct. 2063, 2069, 124 L.Ed.2d 161 (1993) ('appropriate equitable relief' under § 1132(a)(3) includes 'categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)'); *Health Cost Controls v. Skinner*, 44 F.3d 535, 538 n. 4, 5, and 7 (7th Cir. 1995) ('although [plan administrator] clearly cannot recover compensatory damages under [§ 1132(a)(3)], if it successfully makes out a claim for restitution ... it may be entitled to monetary relief'); *UIU Severance Pay Trust Fund v. Local Union No. 18-U*, 998 F.2d 509, 512-13

(7th Cir. 1993) (ERISA permits claim for restitution).

"Restitution is available, however, 'only when one party has been enriched at another's expense.' *Skinner*, 44 F.3d at 538 n. 7. To establish entitlement to the relief it seeks, Campbell must, therefore, demonstrate that:

> (1) [it] had a reasonable expectation of payment, (2) the [plaintiffs] should reasonably have expected to pay, or (3) society's reasonable expectations of person and property would be defeated by nonpayment. C. C. Kaufman, *Corbin on Contracts* § 19A, at 50 (Supp. 1989).

"*Waller*, 906 F.2d at 993-94. It has met that burden in the present case. The undisputed evidence clearly demonstrates that Campbell advanced benefits under the third party exclusion provision with the expectation of being repaid; that the plaintiffs knew that the Campbell Plan contained a third party limitation when they requested and received benefits on Sandra's behalf; and that 'the interests of society, as

> reflected in the goals of ERISA and efficient plan administration, would be served by allowance of an equitable remedy.' *Waller*, 906 F.2d at 993-94." [Footnote omitted]

Petitioners submit that *Provident Life's* analysis of the elements of restitution is correct. Permitting Stone to manipulate the recovery of insurance proceeds by directing them to his children, as petitioners alleged in their complaint below, makes out a colorable case of unjust enrichment. The undisputed facts in this case support a resitutionary remedy.

D. The Panel Opinion in This Case Leaves The Petitioners Utterly Without Remedies to Enforce Written Agreements With Their Participants

The *Owens* panel evidently believed that the plaintiff health plan could obtain reimbursement by suing in state court:

> "FMC will have to pursue its claims under the Plans in state court if it wishes to receive the reimbursement it is allegedly owed by Owens." 122 F.3d at 1261.

The *Stone* opinion, however, makes it clear that the Plan may not proceed in state court. The *Stone* panel rejected the trial court's decision (which, like *Owens*, stated that the Plan could sue in state court) and remanded for dismissal *on the merits*; 197 F.3d at 1008. Because *Stone* finds that there is jurisdiction

over the claim under ERISA, but that ERISA provides no remedy, recognized principles of ERISA preemption mean that no remedy whatsoever exists; see, e.g., *Farr v. U.S. West Communications, Inc.*, 151 F.3d 908 (9th Cir. 1998) *amended by Farr v. U.S. West Communications, Inc.*, 179 F.3d 1252 (9th Cir. 1999), *cert. denied*, ____ U.S. ____, 68 USLW 3291, 3355 (Jan. 18, 2000). See also *Nieto v. Ecker*, 845 F.2d 868 (9th Cir. 1988)[11]

Moreover, state courts have not hesitated to strike down, on ERISA preemption grounds, breach of contract claims brought pursuant to state law to enforce reimbursement agreements; *see*, e.g., *Jefferson Pilot Life Ins. Co. v. Krafka*, 50 Cal.App.4th

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[11]The Ninth Circuit's most recent discussion and analysis of this Court's ERISA preemption cases is *Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson, et al.*, ____ F.3d ____ (U.S.C.A. No. 98-15298, January 12, 2000). Citing this Court's recent decisions in *California Division of Labor Standards v. Dillingham*, 519 U.S. 316, 355 (1997), and *Boggs v. Boggs*, 520 U.S. 833 (1997), the circuit panel acknowledged that the Ninth Circuit "has not arrived upon a single, precise rule that universally determines whether ERISA preempts a state law." After discussing a variety of factors, the panel opinion notes that "the key issue is whether the parties' relationships are ERISA-governed relationships," citing *Geweke Ford v. St. Joseph's Omni Pref. Care*, 130 F.3d 1355, 1360 (9th Cir. 1997). If the Ninth Circuit's analysis of this Court's ERISA preemption decisions is accurate, there seems to be little doubt that ERISA would completely preempt a state law breach of contract claim to compel reimbursement of medical costs advanced by an ERISA-regulated plan. Certainly, the relationship between Plan fiduciaries and participants would fall among the category "ERISA-governed relationships."

1990, 1994 (1996); *A. Copeland Enterprises v. Slidell Memorial Hospital*, 657 S.2d 1293, 1302 (La. 1995); *Funk Manufacturing Co. v. Franklin*, 927 P.2d 944 (Kansas 1996).

Of course, there is nothing whatsoever in the legislative history of ERISA to indicate that Congress intended the enactment of ERISA to completely abrogate a mechanism by which ERISA-regulated plans could lower costs for all participants, by compelling participants to pursue third party wrongdoers for damages, and to contribute the proceeds to the plan to reimburse previously advanced medical and hospital costs.

There is little doubt that reimbursement and subrogation provisions are central to the operation of health plans:

> "Subrogation clauses are a common feature of ERISA plans. While they vary widely in precise operation and effect, they share the goal of limiting the total expenditure of plan assets. Subrogation accomplishes this by permitting the plan to 'stand in the shoes' of the beneficiary with respect to tort or other recoveries to which the beneficiary is entitled on account of the injuries for which the plan has paid benefits. This prevents the beneficiary from recovering twice — once from the plan and once from the tortfeasor .... Subrogation is frequently confused with reimbursement, owing perhaps to the

> frequency with which both provisions are included in ERISA plans." *Waller v. Hormel Foods*, 950 F.Supp. 941, 944 (D. Minn. 1996).

It is utterly inexplicable that the Circuit panel would act to strip ERISA-regulated benefit plans of any remedy whatsoever, simply because enforcement of such agreements would ultimately result in a monetary recovery by the plan. Yet it is clear that that is exactly what the *Stone* panel intended to do.

VI.
CONCLUSION

For the reasons set forth herein, the petition for writ of certiorari should be granted.

Dated: February 11, 2000

Respectfully submitted,

STANTON, KAY & WATSON, LLP

By: JAMES P. WATSON
Counsel of Record for Petitioners

APPENDIX A

FOR PUBLICATION

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA; BOARD OF TRUSTEES OF CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA,
Plaintiffs-Appellants,

v.

RAYMOND STONE,
Defendant-Appellee.

No. 98-16150

D.C. No. CV-97-00931-FCD/PAN

OPINION

Appeal from the United States District Court
for the Eastern District of California
Frank C. Damrell, Jr., District Judge, Presiding

Argued and Submitted
June 17, 1999—San Francisco, California

Filed December 9, 1999

Before: David R. Thompson and William A. Fletcher, Circuit Judges, and Susan Oki Mollway,[1] District Judge.

Opinion by Judge William A. Fletcher

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[1]Honorable Susan Oki Mollway, United States District Judge for the District of Hawaii, sitting by designation.

COUNSEL

James P. Watson, Stanton, Kay & Watson, San Francisco, California, for plaintiffs-appellants Cement Masons Health & Welfare Trust Fund for Northern California, et al.

Daniel E. Wilcoxen and Steven H. Schultz, Wilcoxen, Montgomery & Harbison, Sacramento, California, for defendant-appellee Raymond Stone.

OPINION

W. FLETCHER, Circuit Judge:

On December 19, 1995, Kimberly Stone was trying to rescue an injured dog when she was struck and severely injured

by a passing car. On January 29, 1996, Ms. Stone was recovering from surgery at Chico Community Rehabilitation Hospital when a feeding tube in her abdomen was accidentally dislodged. Hospital staff allegedly reinserted the tube incorrectly, causing a massive infection that resulted in Ms. Stone's death the next day.

Appellant Cement Masons Health and Welfare Trust Fund (Cement Masons) paid $572,325.80 for Ms. Stone's medical expenses from the time of the accident until she died. On the day of her death, Raymond Stone, Ms. Stone's husband and defendant in this action, signed a reimbursement agreement with Cement Masons according to the terms of the Rules and Regulations for the Fund. The agreement required Stone to pursue diligently any claims for medical payments for his wife's injuries against a third party and to reimburse the Fund if he were to recover from such a third party.[2]

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[2]The relevant language of the agreement states:

> . . . [T]he undersigned agrees to reimburse the Fund for any payments made by the Fund on account of hospital, medical, or other expenses in connection with, or arising out of, any injury [for which a third party may be liable or legally responsible] . . . , such reimbursement to be made out of any proceeds received by way of judgment, arbitration award, settlement or otherwise in connection with, or arising out of, any claim for or right to damages by the undersigned or his Dependent against such third party, his insurance carrier, guarantor, or other indemnitor, or by reason of uninsured or under-insured motorist coverage of the undersigned or his Dependent, or any other source of third party recovery.
>
> The undersigned hereby further agrees that the undersigned and his Dependent, if any, will prosecute such claim for damages diligently; will cooperate and assist the Fund in obtaining reimbursement for such payments; will give priority to the reimbursement of the Fund in the allocation of the proceeds of any recovery; will execute any documents necessary to confirm or establish a lien in favor of the Fund on any such claim, action or recovery or damages or to otherwise secure such reimbursement . . . .

On December 18, 1996, Ms. Stone's two minor children, Matthew and Haven Stone, sued the driver of the car through their guardian ad litem, Mary Kay Carlton,[3] seeking damages for negligent infliction of emotional distress. Matthew and Haven settled the suit for $50,000, the coverage limit under the driver's insurance policy.

On January 28, 1997, Raymond Stone, and Matthew and Haven Stone (again through their guardian ad litem), sued the driver of the car; a possible owner of the car; the City of Sacramento; Chico Community Hospital; Chico Community Rehabilitation Hospital; and various hospital staff members. The suit included a wrongful death claim against the driver and possible owner of the car, but the most significant claims were based on the alleged negligence in reinserting the feeding tube. On January 21, 1998, Mr. Stone dismissed all of his claims against the defendants, leaving only Matthew and Haven as plaintiffs in that action.

When Mr. Stone failed to reimburse the Fund out of the $50,000 awarded to his children in the first suit, appellants Cement Masons and its Board of Trustees sued him for restitution under the terms of the reimbursement agreement of the plan and under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1132(a)(3). Appellants argued that Mr. Stone was obligated by the Plan to give priority to claims to recover the medical expenses paid for Ms. Stone's hospitalization and surgeries. According to appellants, Mr. Stone attempted to circumvent his obligation by allowing his children to exhaust the driver's policy limits with their claims for negligent infliction of emotional distress. Appellants contended, further, that Mr. Stone dismissed his own claims in the second lawsuit to prevent the Fund from sharing in any recovery resulting from the wrongful death claim.

[3]The district court, relying on counsel's statements at oral argument, erroneously concluded that Mr. Stone was the guardian ad litem for the two children in the two state court actions. The complaints (provided in the record) list Mary Kay Carlton as the guardian ad litem.

Appellants sought restitution, declaratory relief, and an injunction requiring Mr. Stone (1) to acknowledge the Fund's lien against proceeds recovered from third parties; (2) to advise the Fund of the nature and status of all claims against third parties for damages in connection with Ms. Stone's injuries and death; and (3) to refrain from obstructing the Fund's right to enforce the lien against proceeds recovered by Matthew and Haven Stone.

The district court granted Mr. Stone's motion for summary judgment and dismissed for lack of subject matter jurisdiction. Interpretation of ERISA is a question of law reviewed *de novo*. *See Spink v. Lockheed Corp.*, 125 F.3d 1257, 1260 (9th Cir. 1997). A decision granting summary judgment is reviewed *de novo*. *See Margolis v. Ryan*, 140 F.3d 850, 852 (9th Cir. 1998). Dismissal for lack of subject matter jurisdiction is reviewed *de novo*. *See Tucson Airport Auth. v. General Dynamics Corp.*, 136 F.3d 641, 644 (9th Cir. 1998).

For the reasons that follow, we agree with the district court that appellants' complaint should be dismissed. That dismissal, however, should have been made on the merits rather than for want of subject matter jurisdiction under Fed. R. Civ. P. 12(b)(1).

1. *The Merits of Appellants' Claim*

[1] Injunctive and "other appropriate equitable relief" is available under ERISA, 28 U.S.C. § 1132(a)(3).[4] Such relief includes restitution, *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993), but it does not include contract damages, *id.*, or reimbursement pursuant to contract, *FMC Med. Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997).

[4]"A civil action may be brought . . . (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan . . . ."

We believe that this case is controlled by our decision two years ago in *Owens*, in which we held that reimbursement for payments appropriately made by a plan is not an available remedy under § 1132(a)(3). Applying the Supreme Court's decision in *Mertens*, we held in *Owens* that because the phrase "other appropriate equitable relief" did not encompass FMC's reimbursement claim, ERISA provided no remedy.[5] *See id.* at 1260-1262.

The facts in *Owens* are legally indistinguishable from the facts in this case. The FMC Medical Plan (FMC Plan) in that case provided that if the participant were to bring a liability claim against a third party, the participant must assert a claim for benefits payable under the Plan. *See id.* at 1259. The FMC Plan also provided that upon settlement of a third-party claim, the participant "must reimburse the FMC Plan for the benefits provided." *Id.* The FMC Plan required the participant to sign a reimbursement form in order to receive benefits on any claim with a possibility of third-party liability. *See id.* Owens signed the reimbursement form, which provided:

> I agree for myself and dependent(s), to reimburse FMC Corporation for any amounts paid by the plan and recovered from another person or company. If I bring a claim against any party, benefits payable under this Plan must be included in the claim, and when the claim is settled I must reimburse the Plan for benefits provided.

Id. Owens settled his liability claim against the party responsible for the car accident that had caused the injuries for which the medical expenses were incurred, and FMC sued to enforce the terms of the FMC Plan under § 1132(a)(3). *See id.* We

[5]Distinguishing cases involving ERISA plans that granted the insurer rights of subrogation, the court concluded that FMC's claim was for "contractual reimbursement." *Id.* Like *Owens*, this case does not involve subrogation.

held that FMC's claim was for "contractual reimbursement," a remedy that was not available under § 1132(a)(3). *Id.* at 1260.

[2] As in *Owens*, the Rules and Regulations of the Fund in this case require Mr. Stone to reimburse the Fund for medical payments arising out of claims against third parties. The Fund Rules also require Mr. Stone to give priority to reimbursement of the Fund in allocating payments and to refrain from any acts or omissions that might hinder reimbursement. We believe that the district court properly concluded under *Owens* that appellants are not entitled under § 1132(a)(3) to the remedies they seek. Indeed, appellants appeared to concede as much at oral argument before the district court and before us, where they asserted that *Owens* was wrongly decided.[6]

[3] Appellants also make two arguments why *Mertens* and *Owens* do not control this case. Appellants first contend that they seek "restitution," which they characterize as an equitable remedy. However, restitution, as used in § 1132(a)(3), means "ill-gotten gains," *Mertens*, 508 U.S. at 260, and we have construed ill-gotten gains to mean money obtained through "fraud or wrongdoing," *Owens*, 122 F.3d at 1261. It is undisputed in this case that payment of Ms. Stone's medical bills by appellants was not obtained through fraud or wrongdoing. Cement Masons was required under the terms of the Plan to make those payments, and Cement Masons is not

[6]See, e.g., the following colloquy in the district court:

THE COURT: . . . Tell me how *FMC* [*Owens*] doesn't apply to the facts here.

MS. OLSON: To be perfectly honest, I think *FMC* is — has misinterpreted the *Mertens v. Hewitt* and *McLeod v. Oregon Lithoprint* . . . .

THE COURT: The issue is what am I obliged to do, and I'm just asking you point blank: Are you asking me to ignore *FMC*?

MS. OLSON: I guess so.

challenging their correctness. Rather, appellants contend that Mr. Stone is obliged to reimburse Cement Masons for those payments out of money obtained from third parties, and to pursue claims that might result in obtaining additional money from third parties in the future. Even if Mr. Stone has some obligation to pursue such claims and to reimburse Cement Masons (a question we do not decide), that obligation does not make money previously paid by Cement Masons "ill-gotten gains" subject to restitution within the meaning of § 1132(a)(3).

Appellants next contend that they are entitled to declaratory and injunctive relief requiring Mr. Stone (1) to acknowledge the Fund's lien against funds against third parties; (2) to refrain from obstructing Cement Masons' right to enforce the lien against proceeds recovered by defendant and his dependants from third parties; and (3) to advise Cement Masons of the nature and status of all claims against third parties for damages in connection with Ms. Stone's injuries and death. Appellants attempt to distinguish *Owens* by arguing that such injunctive and declaratory relief, unlike reimbursement, is permissible under § 1132(a)(3).

[4] Unlike the plan in *Owens*, the Cement Masons Fund Rules and Regulations purport to establish an automatic lien on any third-party recovery for benefits paid by the Fund. We do not find that difference material. Two of the three remedies appellants seek depend on the propriety of enforcing the lien. Enforcement of a lien, however, is nothing more than a mechanism to enforce, or to obtain the equivalent of, a damage remedy. Further, on the facts of this case, the only existing fund is the $50,000 received by the two minor children, who have not been made defendants and, in any event, have no obligation whatsoever under the Plan appellants are seeking to enforce. The third remedy appellants seek is an injunction that would require Mr. Stone to keep them informed of claims against third parties. However, it is undisputed that Mr. Stone

has not recovered on third-party claims and is not asserting any new third-party claims.

2. *Dismissal on the Merits*

[5] The district court correctly applied the substantive holding in *Owens* but erred in dismissing for lack of subject matter jurisdiction. The court's error results from some confusion in our case law concerning the appropriate disposition of unsuccessful claims brought under ERISA. In *Owens*, we held that the district court lacked subject matter jurisdiction under ERISA because the Plan's claim was "not cognizable under section 1132(a)(3)." In other cases we have dismissed claims on the merits where § 1132(a)(3) provides no remedy. For example, in *McLeod v. Oregon Lithoprint Inc.*, 102 F.3d 376 (9th Cir. 1996), we affirmed summary judgment on the merits for the defendant, holding that the relief plaintiff sought was not available under § 1132(a)(3). *See also Farr v. U.S. West Communications, Inc.*, 151 F.3d 908 (9th Cir. 1998), amended by 179 F.3d 1252 (9th Cir. 1999), *petition for cert. filed*, 68 USLW 3291 (U.S. Oct. 7, 1999) (No. 99-664) (holding that fiduciary had breached duty under ERISA but affirming summary judgment on the merits for defendant because relief was not available under § 1132(a)(3)); *Pacificare, Inc. v. Martin*, 34 F.3d 834, 835, 838 (9th Cir. 1993) (framing issue in terms of whether plaintiff could state a claim under § 1132(a)(3), not whether there was subject matter jurisdiction). At least two other circuits have concluded that the unavailability of an equitable remedy does not mean that the district court is without subject matter jurisdiction, but, rather, means that the plaintiff has failed to state a claim upon which relief can be granted. *See Blue Cross and Blue Shield of Ala. v. Sanders*, 138 F.3d 1347, 1352-53 (11th Cir. 1998); *Health Cost Controls v. Skinner*, 44 F.3d 535, 537 (7th Cir. 1995).

[6] We hold that a dismissal of an ERISA claim under § 1132(a)(3) is properly a dismissal on the merits rather than a dismissal for want of subject matter jurisdiction. The failure

to state a federal claim, either on the pleadings or the facts, is not the same thing as a failure to establish subject matter jurisdiction. Any non-frivolous assertion of a federal claim suffices to establish federal question jurisdiction, even if that claim is later dismissed on the merits. As the Supreme Court wrote in *Bell v. Hood*, 327 U.S. 678, 682 (1946),

> Jurisdiction . . . is not defeated . . . by the possibility that the averments might fail to state a cause of action on which petitioners could actually recover . . . . If the court . . . exercise[s] its jurisdiction to determine that the allegations in the complaint do not state a ground for relief, then dismissal of the case would be based on the merits, not for want of jurisdiction.

See also Wheeldin v. Wheeler, 373 U.S. 647, 649 (1963) ("We agree . . . that on the face of the complaint the federal court had jurisdiction . . . . But on the undisputed facts, . . . no federal cause of action can be made out.").

[7] In this case, the district court granted summary judgment against Cement Masons. Such a disposition was arguably appropriate, given that defendant had moved for summary judgment rather than for a dismissal under Fed. R. Civ. P. 12(b)(6) for failure to state a claim upon which relief could be granted. We note, however, that defendant more properly should have moved for a dismissal under Rule 12(b)(6), given that he chose to accept as true all of plaintiffs' allegations in the complaint. In either event—whether the dismissal resulted from a summary judgment, or from the granting of a motion under Rule 12(b)(6)—the district court should have dismissed on the merits. Plaintiffs' claim, while unsuccessful and possibly verging on foolhardy given our earlier decision in *Owens*, was not frivolous. A federal court has subject matter to decide a non-frivolous federal claim against a plaintiff, and a decision dismissing the claim is a decision on the merits of that claim.

We therefore AFFIRM the district court's decision dismissing appellants' claim and REMAND for entry of judgment on the merits.

APPENDIX B

FILED
JUN 02 1998
CLERK, U.S. DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA
BY _____
DEPUTY CLERK

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

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CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA and BOARD OF TRUSTEES OF CEMENT MASONS HEALTH AND WELFARE TRUST FUND OF NORTHERN, CALIFORNIA,

Plaintiffs,

v.

RAYMOND STONE,

Defendant.

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NO. CIV. S-97-931 FCD PAN

MEMORANDUM AND ORDER

In this lawsuit, Cement Masons Health and Welfare Trust Fund of Northern California and its Board of Trustees ("plaintiffs") seek declaratory judgment and injunctive relief requiring defendant Raymond Stone ("Stone") to acknowledge plaintiffs' lien for reimbursement of medical expenses paid on behalf of Stone's deceased wife. Characterizing their suit as a claim for restitution, plaintiffs assert their right to reimbursement under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(3). Stone argues that plaintiffs' suit seeks reimbursement, not restitution within the meaning of § 1132(a)(3), and that the court lacks subject matter jurisdiction over plaintiff's claim for reimbursement. The court agrees. Stone's motion for summary judgment is granted.[1]

BACKGROUND

Stone is a cement mason eligible for benefits under the employee benefit trust fund administered by plaintiffs. On December 19, 1995, defendant's wife, Kimberly Stone, was injured in an automobile accident. The minor children, Matthew and Haven Stone, witnessed the accident.

Following the accident, Kimberly was hospitalized at UC Davis Medical Center where she underwent multiple surgical procedures. On January 23, 1996, Kimberly was moved to Chico Community Rehabilitation Hospital to continue her recovery. On

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[1]Stone moves for summary judgment pursuant to rule 56 not dismissal for lack of subject matter jurisdiction pursuant to rule 12(b) (1).

January 29, Kimberly's gastrostomy tube became dislodged causing a massive infection that eventually led to cardiorespiratory arrest and her death on January 30, 1996. Pursuant to its obligations under the plan, the employee benefit trust fund paid $572,325.80 in medical expenses on Kimberly's behalf Stone signed a reimbursement agreement entitling the trust fund to reimbursement for medical expenses from any judgment or settlement proceeds arising from any claim for or right to damages by Stone "or his Dependent" against a third party.

On December 18, 1996, Matthew and Haven Stone, by and through defendant, their guardian and litem, filed a lawsuit alleging negligent infliction of emotional distress to recover for their emotional distress caused by witnessing the collision. On January 27, 1997, Matthew and Haven, by and through defendant, their guardian ad litem, filed a wrongful death action to recover for the medical negligence of the hospital and or physicians who failed to protect Kimberly from dislodging her gastrostomy tube and the inappropriate re-installation of the tube. Stone is not a plaintiff in either action.

STANDARD

Summary judgement in appropriate if the record, read in the light most favorable to the non-moving party, demonstrates no genuine issue of material fact. Fed. R. Civ. P. 56(c); Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). Material facts are those necessary to the proof or defense of a claim, and are determined by reference to the substantive law. See

Anderson v. Liberty Lobby, 477 U.S. 242, 248 (1986).

Summary judgment should be entered, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will beat the burden of proof at trial. "[A] complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial." Celotex, 477 U.S. at 322-23.

ANALYSIS

Section 1132(a) of Title 29 of the United States Code is the civil enforcement provision of ERISA. Section 1132(a) allows a fiduciary to bring a civil action "to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan" or "to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a) (3). "Other appropriate relief" includes injunctive relief and "restitution of ill-gotten plan assets and profits." Mertens v. Hewitt Assoc., 508 U.S. 248, 255, 260 (1993).

Plaintiffs' complaint is entitled "Complaint for Restitution," but plaintiff's claim is for reimbursement, and such monetary relief in not available under § 1132 (a)(3). FMC Medical Plan v. Owens, 122 F.3d 1258, 1261 (9th Cir. 1997). The Ninth Circuit has ruled that, absent an allegation that plan assets were wrongfully acquired, a claim for monetary relief is a claim for reimbursement. Id. at

1261-62. Plaintiffs do not allege that Stone wrongfully or fraudulently procured benefits on behalf of his injured wife. This court lacks subject matter jurisdiction over plaintiffs' claim, and the claim must be dismissed.[2]

CONCLUSION

Defendant's motion for summary judgment is GRANTED.

The Clerk's Office is instructed to close this file.

IT IS SO ORDERED.

DATED: May 29, 1998

/s/ Frank C. Damrell, Jr.

FRANK C. DAMRELL, JR.

UNITED STATES DISTRICT JUDGE

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[2]As in FMC Medical Plan, plaintiffs must pursue their claims in state court. FMC Medical Plan, 122 F.3d at 1262 n.12.

APPENDIX C

29 U.S.C. Section 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought -

(1) by a participant or beneficiary -

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), or (5) of subsection (c) of this

section or under subsection (i) or (l) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [1] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

29 U.S.C. Section 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

MOTION FILED

MAR 2 2 2000

No. 99-1403

In the Supreme Court of the United States

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA and BOARD OF TRUSTEES OF CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA,

Petitioners,

vs.

RAYMOND STONE,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION FOR LEAVE TO FILE AMICUS BRIEF and AMICUS BRIEF IN SUPPORT OF PETITIONERS' PETITION FOR WRIT OF CERTIORARI

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MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE

The International Training Institute for the Sheet Metal and Air Conditioning Industry ("ITI") hereby respectfully moves for leave to file the attached brief amicus curiae in this case. The consent of the attorney for the Petitioner has been obtained. The consent of the attorney for the Respondent was requested but refused.

The interest of the ITI in this case arises from the fact that it operates a Scholarship Loan Agreement ("SLA") Program, whereby individuals receive training at no cost, provided the individual agrees to repay the cost of the training in the event the individual goes to work for an employer that does not contribute to the Joint Apprenticeship and Training Committees. The ITI has been construed by the Department of Labor to be an employee welfare plan within the meaning of ERISA Section 3(1). SLA Programs, identical to the one operated by the ITI, have been found enforceable by other courts. The Ninth Circuit's decision leaves these agreements unenforceable in that Circuit and leaves the ITI with no remedy and jeopardizes the ability of the ITI to operate its apprenticeship and training program.

The ITI supports the Petitioners' petition in this case because the Ninth Circuit's holding extends well beyond the program operated by the Petitioner and has created a conflict among the Circuits.

Dated: March 22, 2000

Respectfully submitted,

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THE INTEREST OF THE *AMICUS CURIAE*[1]

The interest of the ITI in this case arises from the fact that it operates a Scholarship Loan Agreement ("SLA") Program, whereby individuals receive training at no cost, provided the individual agrees to repay the cost of the training in the event the individual goes to work for an employer that does not contribute to the Joint Apprenticeship and Training Committees. The ITI has been construed by the Department of Labor to be an employee welfare plan within the meaning of ERISA Section 3(1). SLA Programs, identical to the one operated by the ITI have been found enforceable by other courts. The Ninth Circuit's decision leaves these agreements unenforceable in that Circuit and leaves the ITI with no remedy and jeopardizes the ability of the ITI to operate its apprenticeship and training program.

SUMMARY OF ARGUMENT

If the Ninth Circuit's decision in *Cement Masons v. Stone* is allowed to stand, SLA Programs such as that operated by the ITI would be unable to operate. These programs serve an important purpose by providing free training to hundreds of thousands of apprentices and journey persons in the construction trades. The Ninth Circuit's decision in *Cement Masons v. Stone* has created a divide among the Circuits over the enforceability of Scholarship Loan Agreement obligations. The proper analysis is that set forth by the Seventh Circuit in *Milwaukee Area Joint Apprenticeship Training Committee for the Electrical Industry v. Howell*, 67 F.3d 1333 (7th Cir. 1995).

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[1] Counsel for a party did not author any part of this brief. No entity other than the *amicus curiae*, its members or its counsel made any monetary contribution to the preparation or submission of the brief.

ARGUMENT

The International Training Institute for the Sheet Metal and Air Conditioning Industry ("ITI") is a jointly administered multiemployer apprenticeship and training fund. It was established by and is sponsored by the Sheet Metal Workers International Association and the Sheet Metal and Air Conditioning Contractors' National Association. It is an apprenticeship and training fund within the meaning of Section 3(1) of ERISA.[2] It is affiliated with over 100 local and regional joint apprenticeship and training committees throughout the country in the sheet metal industry. The ITI develops training material and provides courses of instruction to train instructors in the sheet metal industry. Together the ITI and the local Joint Apprenticeship and Training Committees ("JATC") have trained hundreds of thousands of apprentices and journey persons in the sheet metal industry in the last 28 years.

In 1984, the ITI (under its predecessor name of the National Training Fund for the Sheet Metal and Air Conditioning Industry) developed a program known as the Scholarship Loan Agreement Program.

The Scholarship Loan Agreement ("SLA") Program is also used by other sectors of the building trades and the SLA Program is one of the reasons why the apprenticeship and training programs in the building and construction industry are so successful and are able to provide skilled workers in the construction industry, at no cost to the individual being training.

The heart of this program is the Scholarship Loan Agreement between the ITI, the local JATC and the soon to be

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[2] The Department of Labor in an advisory opinion letter dated January 8, 1979, concluded that the International Training Institute was an employee welfare benefit plan within the meaning of ERISA Section 3(1).

indentured apprentice, whereby the individual is trained at no cost, provided the individual is willing to make a commitment to the industry that trained him or her by continuing to work under collective bargaining agreements that provide for contributions to the local JATCs and to the ITI. If the individual leaves the industry, there is no further obligation pursuant to the agreement. However, if the individual, upon completion of the training, goes to work for an employer that does not have an obligation to contribute to the ITI and the local JATC, the individual is obligated to pay for the cost of the training which in turn allows other individuals to be trained. The enforceability of these SLA's has been upheld by other courts in other circuits. See *Milwaukee Area Joint Apprenticeship Training Committee for the Electrical Industry v. Howell*, 67 F.3d 1333 (7th Cir. 1995). *Howell* involved a scholarship loan agreement document identical to the one used by the ITI.

Not only have the courts upheld the enforceability of these agreements, they have presented persuasive rationale for the existence of these repayment obligations. In *National Training Fund v. Maddux*, 751 F. Supp. 120 (S.D. Tex. 1990), the court found that the ITI's SLA Program was in the interest of public policy when it stated:

> These national training Funds are not charities, giving away their resources. The Funds train a limited number of people who will directly benefit the members . . . . The reimbursement prevents freeloading by neighboring competitors. Because they do not pay for the program, they can pay workers slightly more than the members can at the same total cost. The public is best served by enforcement of a reasonable reimbursement provision.
>
> Without a check on freeloading by non-participating companies, the Funds would not have trained [the apprentice]. The work-or-pay provision is

> what allowed [him] to acquire his new skill. The reimbursement makes a non-participating employer equal to a participating employer if he pays the reimbursement, either in the form of a lump sum or a higher salary to get the trained worker.

Maddux, 751 F. Supp. at 121-122.

If the Ninth Circuit's decision in *Cement Masons v. Stone* is allowed to stand, the ITI and all other local, regional and national joint apprenticeship and training funds in the Ninth Circuit will be unable to enforce their SLA obligations. They will not be able to bring suit in federal court in the Ninth Circuit, nor will they be able to bring suit in state court. The SLA Program is one of the terms of the ITI's and local JATC's plan of benefits and therefore ERISA would preempt any and all state laws and actions relating to this program.

Cement Masons v. Stone is in direct conflict with *Milwaukee Area Joint Apprenticeship Training Committee for the Electrical Industry v. Howell*, 67 F.3d 1333 (7th Cir. 1995).

Cement Masons v. Stone is also in direct conflict with *Health Cost Controls of Illinois, Inc. v. Washington*, 187 F.3d 703 (7th Cir. 1999). This case, like *Cement Masons*, was a subrogation case. Although *Health Cost* was decided four months before *Cement Masons*, the reasoning of the line of cases that *Cement Masons*, was based upon was specifically rejected by the 7th Circuit when it stated:

> So Health Cost is indeed seeking a constructive trust and while the Ninth Circuit appears to believe that the imposition of a constructive trust in an ERISA case is permissible only when there has been a breach of trust, *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1261(9th Cir. 1997), it has given no reason for this belief and there is no basis for it either in ERISA or in the

> principles of equity . . . . Alternative characterizations of Health Costs' claims (alternative to both restitution and constructive trust)–as seeking to impose an equitable lien on the escrow account or seeking a mandatory injunction directing Washington to sign over her claim to the money–are also permissible, moreover, and they reinforce our conclusion that Health Cost's claim is securely equitable and so within the jurisdiction conferred on the district court by ERISA.

Washington, 187 F.3d at 711.

Cement Masons v. Stone is in direct conflict with *Health Cost Controls of Illinois Inc. v. Washington*, 187 F.3d 703 (7th Cir. 1999).

CONCLUSION

For the reasons set forth herein, petition for writ of certiorari should be granted.

Dated: March 22, 2000 Respectfully submitted,

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MAR 2 4 2000

(3)

No. 99-1403

IN THE
Supreme Court of the United States

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA AND BOARD OF TRUSTEES OF CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA,

Petitioners,

v.

RAYMOND STONE,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF OF THE MULTIEMPLOYER TRUST FUNDS AS AMICUS CURIAE IN SUPPORT OF THE PETITION

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IN THE

Supreme Court of the United States

No. 99-1403

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA AND BOARD OF TRUSTEES OF CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA,

Petitioners,

v.

RAYMOND STONE,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE

To the Honorable Chief Justice and Associate Justices of the Supreme Court of the United States:

The Hotel Employees Local 5 Health and Welfare Trust, Operating Engineers Health and Welfare Trust, Operating Engineers Local 3 Health and Welfare Trust, Laborers Regional Council of Northern California Health and Welfare Trust, and Carpenters Regional Council of Northern California Health and Welfare Trust (the "Trust Funds") hereby move the Court pursuant to Supreme Court Rule 37.2 for leave to file the accompanying brief as amici curiae in support of the Petition for Writ of Certiorari filed on February 22, 2000 in U.S.C.C. No. 99-1403.

In support of this motion, the Trust Funds state the following.

1. This motion is necessitated by the failure of respondent Raymond Stone, upon request, to give written consent to the filing of a brief by the amici applicants herein.

2. The Trust Funds are multiemployer trust funds established pursuant to the provisions of Labor Management Relations Act of 1974, as amended, Section 302(c), 29 U.S.C. § 186(c). All of the Trust Funds are employee benefit funds within the meaning of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, and are subject to federal regulation pursuant to the provisions of ERISA.

3. Each Trust Fund administers benefit Plans ("Plan" or "Plans") that are funded with monies that otherwise would be paid to employees as wages or salaries. The benefit Plans administered by the Trust Funds contain reimbursement provisions, under which Plan participants agree to reimburse the Trust Funds for benefits received if the Plan participant secures a judgment or settlement from a third party who caused the injury relative to which Plans funds were expended on behalf of the participant.

4. The Trust Funds seek leave to file the attached brief in order to make this Court aware of the serious legal, fiscal, and public policy implications of the Ninth Circuit's ruling in *Cement Masons Health & Welfare Trust Fund v. Stone*, 197 F.3d 1003 (9th Cir. 1999). The Ninth Circuit's holding in *Stone* that "other equitable relief" available under ERISA Section 502(a)(3), 29 U.S.C. § 1132(a)(3) does not include reimbursement of benefit expenditures from Plan participants who secure both Plan coverage and a money judgment or settlement from a third party for the same incident, is in conflict

with decisions on point from the Seventh, Eighth and Eleventh Circuits. The Ninth Circuit's holding threatens the fiscal stability of the Trust Funds. Moreover, because there is a deep, fundamental split among the federal circuits with regard to this issue, the Congressional purpose of having a uniform system of employee benefit administration is being thwarted. Only a decision by this Court will resolve this problem.

5. These amici are in a unique position to advise the Court with regard to the implications of the *Stone* decision because of their familiarity with the structure, administration, and purposes of multiemployer trust funds as well as with their reliance on the type of reimbursement clauses affected by the *Stone* decision.

WHEREFORE, the Trust Funds respectfully request that they be granted leave to file the accompanying brief as amici curiae.

Respectfully submitted,

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March 24, 2000

QUESTION PRESENTED

Whether, under Employee Retirement Income Security Act Section 502(a)(3), 29 U.S.C. Sec. 1132(a)(3), a multiemployer Plan may seek reimbursement of benefits paid to a Plan participant who secures compensation for the covered injury through a tort judgment or settlement from a third party who caused the covered injury?

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IN THE

Supreme Court of the United States

No. 99-1403

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA AND BOARD OF TRUSTEES OF CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA,

Petitioners,

v.

RAYMOND STONE,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE MULTIEMPLOYER TRUST FUNDS AS AMICI CURIAE IN SUPPORT OF THE PETITION

NOW COME the Amici Curiae,* Hotel Employees Local 5 Health and Welfare Trust, Operating Engineers Health and Welfare Trust, Operating Engineers Local 3 Health and Welfare Trust, Laborers Regional Council of Northern California Health and Welfare Trust, and Carpenters Regional Council of Northern California Health and Welfare Trust (the "Trust Funds") and submit this brief in support of the Petition for Writ of Certiorari in No. 99-1403.

* No counsel for any party to this dispute authored this brief in whole or in part and no person or entity, other than *amici curiae* and their members, made a monetary contribution to the preparation or submission of this brief. Petitioners have consented to the filing of this brief and their letter of consent has been filed with this Court. Respondent denied consent.

INTEREST OF THE AMICI CURIAE

A statement describing the Trust Funds and their interest in this case is set forth in the accompanying motion requesting leave to file this brief as amici curiae.

SUMMARY OF ARGUMENT

The Court should grant certiorari to resolve the conflict among the federal courts of appeals regarding whether, under ERISA Sec. 502(a)(3), 29 U.S.C. § 1132(a)(3), a multiemployer Plan can seek reimbursement of benefits paid to a Plan participant who secures compensation for the same injury through a tort judgment or settlement.

Multiemployer trust funds are established through collective bargaining and are funded with employee compensation. Plan trustees must balance contribution income against fund expenditures and administration costs to ensure the delivery of satisfactory benefits to Plan participants. Because the contributions derive from employee compensation and are determined through collective bargaining, a change in Plan expenditures, including a change resulting from the elimination of the right to reimbursement from participants who obtain a double recovery for their injuries, can upset budgetary stability, forcing the trustees to reduce or interrupt benefits to keep the Plan solvent and functional.

The Ninth Circuit's ruling that reimbursement is unavailable as "other appropriate equitable relief" under ERISA Sec. 502(a)(3) leaves the Trust Funds with no remedy when a Plan participant is doubly enriched by obtaining both Plan coverage and reimbursement from the tortfeasor who caused the covered injury.

The decision below is in conflict with decisions from the Seventh, Eighth, and Eleventh Circuits. That inter-

jurisdictional conflict has undermined the uniform administration of employee benefits Congress sought to put in place when it enacted ERISA. Many trust funds cover multiple states or the entire nation, using pooled resources to purchase and provide benefits to employees across appellate jurisdictions, using funds contributed from equally diverse sources. Lack of uniformity in the federal rules governing when reimbursement may be obtained results in undue administrative costs and burdens. Employees from a jurisdiction that allows reimbursement are placed in the untenable position of funding benefits to doubly enriched employees from jurisdictions that prohibited Plans from seeking reimbursement from doubly compensated Plan participants.

The Ninth Circuit's rationale below, that restitution, an equitable remedy, cannot be used to obtain reimbursement of Plan benefits under a reimbursement clause unless the Plan participant has engaged in "fraud or wrongdoing" is unsupported by precedent or equity principles. Restitution is an equitable remedy for unjust enrichment, an equitable cause of action designed to disgorge an unfairly received windfall, regardless of whether the recipient engaged in any wrongdoing. The Ninth Circuit's reliance on this Court's analysis in *Mertens v. Hewitt Associates*, 508 U.S. 248, 124 L.Ed.2d 161, 113 S.Ct. 2063 (1993) is misplaced, as that decision did not hold that restitution is available only when the unjustly enriched party engaged in fraud or wrongdoing.

The Ninth Circuit's recent reaffirmation of its erroneous interpretation of *Mertens* and its continued refusal to allow parties to seek reimbursement of Plan payments under ERISA Sec. 502(a)(3), have deepened the intercircuit conflict on this issue, necessitating a decision by this Court to establish a nationwide interpretation of Sec. 502(a)(3). Granting the Petition for Writ of Certiorari

will give this Court an opportunity to definitively rule on this divisive issue.

REASONS THE WRIT SHOULD ISSUE

I. The Trust Funds' Ability to Obtain Reimbursement Of Plan Benefit Payments From Participants Who Secure Compensation For a Covered Loss From the Party Who Caused It Is a Critical Component of Responsible Multiemployer Plan Administration; Lack of Federal Uniformity Regarding Availability of Reimbursement Creates Administrative Burdens and Inequities That Congress Sought to Elimnate With ERISA.

The Ninth Circuit's decision in *Cement Masons Health and Welfare Trust Fund v. Stone*, 197 F.3d 1003 (9th Cir. 1999), and that court's unappealed decision in *FMC Medical Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997) on which the Ninth Circuit purported to base its decision in *Stone*, create a conflict among the federal circuit courts regarding whether ERISA-governed multiemployer Plans can secure reimbursement from Plan participants who both receive Plan benefits and then secure a money judgment or settlement for the same injury. Multiemployer Plans commonly include reimbursement provisions and depend on reimbursement to limit costs while ensuring that participants are fully covered for relevant losses.

Because multiemployer Plans must carefully balance contribution income against Plan expenditures and administration costs to assure consistent delivery of satisfactory employee benefits, the availability of reimbursement of benefit payments from participants who secure a remedy for their loss from another source is a critical factor in fiscal Plan administration. In addition, because many multiemployer Plans cover more than one state or the entire nation, variation among the federal circuits with

regard to the availability of reimbursement under ERISA Sec. 502(a)(3) thwarts the Congressional purpose of creating a uniform federal program for employee benefits administration and impedes the orderly administration of multiemployer Plans.

A "multiemployer Plan" is an employee health and welfare benefit or pension Plan that is created and maintained through one or more collective bargaining agreements betwen one or more labor organizations and more than one employer. Such Plans are funded through employer contributions derived from a portion of employee compensation that is set aside for the benefit Plan.

When employers and labor organizations establish a multiemployer Plan, they enter into an agreement and declaration of trust which creates an employee benefit trust fund and defines the rights and responsibilities of the trustees who shall administer it. The board of trustees is composed of an equal number of labor and management representatives. Some multiemployer Plans are limited to local regions, but some are inter-state, involving employers from multiple states. Some Plans are nationwide in coverage.

Funds from participating employer contributions are pooled and invested by the Plan trustees. Economics of scale enable multiemployer Plans to secure competitive benefits for covered employees. However, the income for multi-employer funds is established through collective bargaining and is derived from employee compensation, so the funds are subject to a specific limit for each multiemployer Plan and fluctuation in the cost of administering the funds can have a profound impact on the benefits available to covered employees.

Multiemployer Plan trustees are charged with ensuring that employee contributions are used to secure reliable,

satisfactory health and welfare benefits for Plan participants. To carry out that duty, the trustees must balance Plan contributions (derived from compensation paid to covered employees for covered work) against Plan costs, including payment of benefits for participants and beneficiaries, premium payments for insurance secured on behalf of participants, and costs of administering the Plan. In balancing income and expenses, Plan trustees establish participation eligibility rules, benefits packages, and operational practices for the peculiar circumstances of that Plan, its participants, and the industry within which it was established.

A change in expenditures, whether resulting from an increase in benefits payments, insurance premium rates, or the elimination of the right to reimbursement from participants who obtain a double recovery for their injuries, can seriously destabilize a multiemployer Plan's budget, resulting in reduction or interruption of employee benefits in the short term and increased contribution cost in the long term. Moreover, increasing contributions must be accomplished through collective bargaining, so a sudden increase in Plan costs can hamstring a multiemployer Plan until participating employers and unions can bargain a new agreement. Employers cannot simply unilaterally increase contribution rates.

One result of the fiscal constraints imposed by the requirement that changes in contributions be accomplished through collective bargaining is that Plan trustees must resort to such budget balancing tools as adjusting eligibility rules, reducing benefit levels, increasing out-of-pocket participant charges, and eliminating types of benefits. Each of those mechanisms decreases the desirability of the multiemployer Plan to participating employees.

Among the choices the Plan administrators must undertake is whether to make the Plan "self-funding" with re-

gard to particular benefits or to secure outside insurance coverage and use Plan funds to pay the premiums. The availability of reimbursement (or lack thereof) of benefit funds from participants who have secured a double recovery (through benefit coverage and litigation proceeds) has a substantial impact on a multiemployer Plan regardless of whether it is self-funded or utilizes outside insurance. A self-funded Plan will be greatly affected in the short term if it pays a claim and cannot secure reimbursement. A Plan that utilizes insurance will suffer ongoing extra expenses in the form of increased premiums in jurisdictions that interpret ERISA to preclude reimbursement from Plan participants who secure money judgments or settlements from third parties who caused the injuries covered by the Plan.

In addition, retirement benefits are generally subsidized by currently working employees' contributions to multiemployer Plans and are subject to jeopardy in the event of unrecoverable drains on the Plan budget.

Multiemployer Plans are the product of collective effort by responsible employees and cooperative employers to secure affordable, reliable employee benefits for participants and their families. Participation is such Plans, although encouraged by Congress through the enactment of ERISA, is strictly voluntary. In order to maintain an incentive for such participation, it is critical to avoid unnecessarily undermining the financial viability of pooling resources and purchasing benefits on behalf of large numbers of employes within the regulatory scheme established by ERISA. When administering multiemployer Plans becomes too expensive for employers or results in inadequate benefits to employees, the system of benefits administration envisioned by the drafters of ERISA begins to crumble.

One way Congress sought to make multiemployer Plans affordable and practically administrable was by implementing a uniform federal regulatory scheme and preempting state regulation. Congress sought to avoid unworkable administrative burdens and devastating costs that would result from a requirement that multiemployer Plans comply with regulatory schemes that shift across state lines.

That lack of uniformity is no less pronounced where, as here, the federal circuit courts have issued conflicting decisions on an issue as fundamental to Plan administration as whether multiemployer Plans can secure reimbursement for Plan expenditures from employees whose covered injuries have been compensated through collateral sources.

As noted above, many Plans cover employees in multiple states and some Plans have nationwide coverage. Accordingly, contributions are submitted from multiple states, benefits are administered in those states, and Plan administrators are forced to contend with conflicting reimbursement standards. Since the Plan operates with pooled resources, the result of inter-circuit conflicts is that participants from a state where reimbursement is available will be contributing to coverage for doubly-enriched employees from jurisdictions where reimbursement is not available.

Even Plans that primarily cover local areas have participants and beneficiaries who work or live in other states. So, federal litigation could arise in a jurisdiction that prohibits reimbursement, even when the Plan is administered in a jurisdiction that allows reimbursement creating unbearable burdens on the trust administrators, the Plan budget (and, therefore, the Plan participants who fund it), as well as the courts.

This Court has observed that Congress sought to avoid such a multiplicity of regulations. *New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Company*, 514 U.S. 645, 656, 131 L.Ed.2d 695, 115 S.Ct 1671 (1995). "Congress intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives . . . and to prevent the potential for conflict in substantive law requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *Id.* (citations, ellipses, and brackets omitted.) Congress sought uniformity in order to avoid "inefficiencies that employers might offset with decreased benefits." *FMC Corp. v. Holliday*, 498 U.S. 52, 60, 112 L.Ed.2d 356, 111 S.Ct. 403 (1990).

Those Congressional goals are no less frustrated by the imposition of differing rules between federal appellate jurisdictions than by conflicts resulting from different state regulatory schemes. The conflict created by the Ninth Circuit's ruling in *Stone* is at odds with Congress's intent to create a uniform federal system of employee benefits administration and should be resolved by way of a ruling from this Court. For this reason, and because the Ninth Circuit's analysis in *Stone* is critically flawed, the Petition for Certiorari should be granted.

II. The Ninth Circuit's Recently Reaffirmed Analysis Misinterprets this Court's Decision in *Mertens v. Hewitt Associates* and Conflicts With the Relevant Rulings From Every Other Circuit That Has Addressed the Availability of Reimbursement Under ERISA Sec. 502(a)(3), Necessitating Action By This Court.

In both *Stone* and *Owens*, the Ninth Circuit held that a multi-employer Plan fiduciary cannot utilize ERISA

Section 502(a)(3) to obtain reimbursement from a Plan participant who has secured compensation for the covered loss from a third-party tortfeasor, even though the Plan and a contract with the participant both mandated such reimbursement. *Stone*, 197 F.2d at 1006; *Owens*, 122 F.2d at 1262. The Ninth Circuit reasoned that "other appropriate equitable relief" available under Sec. 502 (a)(3) only included traditional equitable remedies, not money damages.

The Ninth Circuit rejected the argument that the Plan could secure reimbursement through the equitable remedy of restitution, citing this Court's decision in *Mertens v. Hewitt Associates*, 508 U.S. 248, 260 (1993) for the proposition that "restitution, as used in Section 1132 (a)(3), means 'ill-gotton gains,'" interpreted as "money obtained through 'fraud or wrongdoing.'" *Stone*, 197 F.3d 1003, 1006-1007 (quoting *Mertens, supra*, and *Owens*, 122 F.3d at 1261.) The Ninth Circuit's terse analysis misstates this Court's holding in *Mertens*.

In *Mertens*, Plan participants whose retirement benfits were reduced because of a non-trustee actuary's negligence sought to hold the actuary accountable under ERISA Sec. 502(a)(2) for knowingly participating in the fiduciaries' breach of their fiduciary duties. In arguing that the remedies available under Section 502(a)(3) extended to money damages against non-fiduciaries like the actuary, the employees contended that "other appropriate equitable relief" should include all remedies traditionally available in courts of equity, including, under certain circumstances, money damages. *Mertens* at 257.

To support that argument, the employees pointed to ERISA Section 502(1), 29 U.S.C. § 1132(I) which allows the Secretary of Labor to assess a civil penalty in cases of breach of fiduciary duty or knowing participation

therein by a non-fiduciary. *Mertens* at 259-260. The measure of damages the Secretary can impose under 502(1), 29 U.S.C. § 1132(1) is defined as "any amount ordered by a court to be paid by such fiduciary or other person to a Plan or its participants or beneficiaries in a judicial proceeding instituted by the Secretary under Section 502(a)(2), 29 U.S.C. § 1132(a)(2) or Section 502(a)(5), 29 U.S.C. § 1132(a)(5)." So, they argued, "other appropriate equitable relief" within Sec. 502(a)(2) includes money damages. *Id.* at 260.

Since 502(a)(5) authorizes actions by the Secretary for "other appropriate equitable relief," just as 502(a)(3) does for private litigants, reasoned the employees in *Mertens*, 502(a)(3) must allow actions for money damages as well. Such a reading is necessary in order to give the same words the same meaning throughout the statute, they argued. *Id.*

A five-to-four majority of this Court found that it was not necessary to construe "other appropriate equitable relief" to include all remedies available in the courts of equity in order to explain the ability of the Secretary to secure a monetary penalty under ERISA Sec. 502(a)(5). "For even in its more limited sense, the 'equitable relief' awardable under Section 502(a)(5) includes restitution of ill gotton Plan assets or profits, providing an 'applicable recovery amount' to use to calculate the penalty," said this Court.

Mertens did not hold that restitution was *only* available for recovery of "ill-gotton" assets, *Mertens* said that a narrow reading of "other appropriate equitable relief" "*includes*" ill-gotton gains. That observation was designed to negate the employees' argument that, in order for the Secretary's power to secure a monetary award for a fiduciary breach, "other appropriate equitable relief" had to

be read expansively to include money damages traditionally available in certain equity actions.

Thus, the Ninth Circuit took the "ill-gotton Plan assets" language out of context and misconstrued it when the appellate court relied on *Mertens* for the proposition that restitution is only available upon proof of wrongdoing by the person or entity from whom restitution is sought. To the contrary, restitution has traditionally been available as a remedy for unjust enrichment, an equitable cause of action to disgorge monies that unjustly ended up in a party's hands, regardless of whether that party engaged in any bad faith conduct.

For purposes of unjust enrichment, the question is whether the possessor of the money sought to have received it and whether the party bringing the action has a right to take it. C. Kaufman, Corbin on Contracts, Section 19A (Supp. 1989). It is possible for the unjustly enriched to have received the unjust windfall because of the misconduct of a third party, or because of circumstances beyond all parties' control. Misconduct by the unjustly enriched party is not necessary for the cause of action to lie.

Thus, the Ninth Circuit's reliance on *Mertens* for the proposition that reimbursement is only available as restitution under ERISA Sec. 502(a)(3) if it can be shown that the enriched Plan participant engaged in "fraud or wrongdoing" is without merit or legal support.

The Ninth Circuit's analysis is at odds with the Seventh, Eighth, and Eleventh Circuits. In *Blue Cross & Blue Shield of Alabama v. Sanders*, 138 F.3d 1347, 1353 n.5 (11th Cir. 1998), the Eleventh Circuit rejected the Ninth Circuit's analysis in *Owens* as an "unduly narrow reading" of *Mertens*. The court in *Blue Cross* observed that specific performance is a traditional equitable rem-

edy that can be used to force a party to honor its monetary duties under a contract. That remedy was not foreclosed by *Mertens*, reasoned the court in *Blue Cross*. *Id.*

In *Southern Council of Industrial Workers v. Ford*, 83 F.3d 966, 969 (8th Cir. 1996), the Eighth Circuit found that a claim for reimbursement "is a claim that [the third party beneficiary] failed to comply with a term of the Plan." Such a contention was equivalent to a claim for specific performance, reasoned the court, which is an equitable remedy and, therefore, is available under ERISA Sec. 502(a)(3). *Id.*

In *Administrative Committee v. Gauf*, 188 F.3d 767 (7th Cir. 1999), the Plan administrators sought reimbursement from a participant who, after receiving benefits coverage for medical care, recovered damages against the tortfeasor who caused her injuries. *Id.* at 769. The participant argued, as held by the Ninth Circuit in *Owens* (and *Stone*), that the action for reimbursement was tantamount to an action for money damages which are not available under ERISA Sec. 502(a)(3). *Id.* at 770 The Seventh Circuit expressly rejected *Owens*, finding that the action for reimbursement sought to compel the Plan participant to honor her agreement with the Plan, which was in the nature of an equitable action for specific performance, falling within the terms "other appropriate equitable relief" in Sec. 502(a)(3). *Id.*

The Seventh Circuit again criticized the Ninth Circuit's reasoning in *Owens* in *Health Cost Controls of Illinois, Inc. v. Washington*, 187 F.3d 703, 711 (7th Cir. 1999), *cert. denied*, —— U.S. ——, 145 L.Ed.2d 930, 120 S.Ct. 979 (2000). The Seventh Circuit found that reimbursement could be obtained under ERISA Sec. 502(a)(3) through the equitable mechanism of a constructive trust. Washington flatly rejected the Ninth Circuit's holding to

the contrary in *Owens*, stating, "[W]hile the Ninth Circuit appears to believe that the imposition of a constructive trust in an ERISA case is permissible only when there has been a breach of trust, *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1261 (9th Cir. 1997), it has given no reason for this belief and there is no basis for it either in ERISA or in the principles of equity." *Washington*, 187 F.3d at 711.

In February 2000, the Ninth Circuit reaffirmed its interpretation of *Mertens, supra*, in the face of the criticism from the Eleventh Circuit in *Blue Cross, supra. Reynolds Metals v. Ellis*, 202 F.3d 1246 (9th Cir. 2000). Thus, the Ninth Circuit has entrenched itself in holding that reimbursement from a doubly enriched Plan participant is unavailable under ERISA Sec. 502(a)(3), in opposition to the holdings of the Seventh, Eighth, and Eleventh Circuits, and in reliance on a faulty interpretation of this Court's ruling in *Mertens, supra.*

The result of the Ninth Circuit's holding is to render multi-employer Plans like the amici powerless to recoup benefit paid to a participant who recovers his or her loss from the tortfeasor who caused it. Such an outcome thwarts the Congressional purpose of ensuring that multi-employer Plans remain funded in order to maximize the provision of affordable health and welfare benefits to employees who bargain collectively with their employers for such coverage. This Court's intervention is required in order to address this critical issue under ERISA and to bring the Ninth Circuit into line with the better reasoned analyses of the other Circuits, in order to establish the uniform system of benefits administration Congress intended to implement with the passage of ERISA.

CONCLUSION

For the reasons set forth herein, the Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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No. 99-1403

In the Supreme Court of the United States

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA and BOARD OF TRUSTEES OF CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA PLAN,

Petitioners,

v.

RAYMOND STONE,

Respondent.

On Petition for a Writ of *Certiorari* to the United States Court of Appeals for the Ninth Circuit

MOTION FOR LEAVE TO FILE A BRIEF AS *AMICUS CURIAE* AND BRIEF OF *AMICUS CURIAE* CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND IN SUPPORT OF PETITION FOR WRIT OF *CERTIORARI*

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MOTION FOR LEAVE TO FILE A BRIEF *AMICUS CURIAE*

Central States, Southeast and Southwest Areas Health and Welfare Fund ("Welfare Fund"), pursuant to Supreme Court Rule 37, respectfully moves this Honorable Court to grant it leave to file a brief *amicus curiae* in support of the Petition for Writ of *Certiorari* filed by Cement Masons Health and Welfare Fund for Northern California and its Board of Trustees. The Welfare Fund submits its brief *amicus curiae* together with this motion. In support, the Welfare Fund states:

1. Petitioners Cement Masons Health and Welfare Trust Fund for Northern California ("Cement Masons Fund") and its Board of Trustees have consented to the filing of the Welfare Fund's brief *amicus curiae*. Respondent Raymond Stone has refused to consent to the filing of the Welfare Fund's brief *amicus curiae*. Copies of Petitioner's and Respondent's letters accompany this motion for filing with the Clerk of this Court.

2. The Welfare Fund is a Taft-Hartley trust and an employee benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002(1). *See Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 561-62 (1985), *reh'g denied*, 473 U.S. 926 (1985). Welfare Fund beneficiaries are teamsters and dependents of teamsters (collectively, "Beneficiaries") from local unions throughout the country who negotiate collective bargaining agreements with their employers. The employers pay contributions to the Welfare Fund to fund benefits for Beneficiaries.

3. The Welfare Fund provides medical, hospital, dental, disability, vision and life benefits to more than three hundred thousand Beneficiaries who reside in thirty-six states. The Welfare Fund is self-funded and not-for-profit. Like the Cement Masons Fund, the Welfare Fund has implemented a subrogation program which it actively enforces in all jurisdictions where its Beneficiaries reside.

4. The Welfare Fund seeks leave to file its brief *amicus curiae* to bring to the attention of the Court relevant matters not raised by Petitioner. Not considered by Petitioner is the effect which the Ninth Circuit's decision will have on large employee benefit plans which operate in many states. For employee benefit plans such as the Welfare Fund, as well as the myriad other plans which have many beneficiaries and which operate in many states, the decision of the Ninth Circuit will cause the exact harm which Congress sought to prevent in enacting ERISA.

5. In enacting ERISA, Congress recognized the importance of employee benefit plans, the problems which conflicting state and local regulation could cause for such plans, and the need for exclusive federal regulation of such plans to ensure uniformity in enforcement of plan terms. This Honorable Court has, on many occasions, noted these laudable goals of ERISA. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983) (quoting 120 Cong. Rec. 29933 (1974)); *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990).

6. The Ninth Circuit's decision not only creates a split in the Circuits, but also directs plans to state court as the

exclusive forum for enforcing the terms of the plan and redressing violations of the terms of the plan. For these reasons, that decision will create the exact patchwork enforcement of plan terms which Congress sought to avoid in enacting ERISA.

7. As discussed in the brief *amicus curiae*, because ERISA preempts state laws, 29 U.S.C. § 1144(a), and provides plan fiduciaries with access to federal district courts which have exclusive jurisdiction in actions to enforce plan terms and redress violations of plan terms, 29 U.S.C. §§ 1132(a)(3) and 1132(e), directing fiduciaries to state courts for such actions may result in no remedy at all. Moreover, that direction invites state courts to apply a wide range of varying state laws which diminish or eliminate subrogation rights in different ways from state to state.

8. Finally, subrogation results in significant cost-savings for the Welfare Fund. Since its inception in 1984, the Welfare Fund's subrogation program has achieved direct reimbursements and savings of approximately $62.0 million. Because the decision of the Ninth Circuit will result in the diminishment of subrogation recoveries and savings, that decision will lead to the inevitable reduction in benefits for Beneficiaries—a result which further detracts from ERISA's goals as described in *Shaw*, 463 U.S. at 99, and *FMC*, 498 U.S. at 60.

For each of the above reasons, the Central States, Southeast and Southwest Areas Health and Welfare Fund requests this Honorable Court to grant it leave to file the Welfare Fund's brief *amicus curiae*.

Respectfully submitted,

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BRIEF OF *AMICUS CURIAE*

I. THE INTEREST OF THE *AMICUS CURIAE*

Central States, Southeast and Southwest Areas Health and Welfare Fund ("Welfare Fund") is an employee benefit plan as defined in Section 3(1) of the Employee Retirement and Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002(1). *See Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 561-62 (1985), *reh'g denied*, 473 U.S. 926 (1985).[1] Welfare Fund beneficiaries are teamsters and dependents of teamsters (collectively, "Beneficiaries") from local unions throughout the country who negotiate collective bargaining agreements with their employers. These collective bargaining agreements require employers to pay a certain level of contributions to the Welfare Fund in return for a set benefit package offered by the Welfare Fund for that particular contribution rate. Each contributing employer executes a participation agreement with the Welfare Fund agreeing, among other things, to pay the required contributions and to abide by all rules and regulations set by the Welfare Fund Trustees who administer the Welfare Fund. Established under the Taft-Hartley Act, the Welfare Fund has ten trustees—five appointed by contributing employers and five elected by the unions whose members are Beneficiaries. *See* 29 U.S.C. § 186.

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[1] As provided in United States Supreme Court Rule 37.6, the Welfare Fund states that no counsel for any party authored any part of this brief, and that no person other than *amicus curiae*, its members, or its counsel made any monetary contribution to the preparation or submission of the brief.

The Welfare Fund provides medical, hospital, dental, vision, life and disability benefits to more than three hundred thousand Beneficiaries who reside in thirty-six states. The Welfare Fund is self-funded and pays benefits directly from the contributions of participating employers. The Welfare Fund is not-for-profit, and its assets are used exclusively to provide benefits for Beneficiaries or to defray the reasonable costs of administering the benefit plan. *See* 29 U.S.C. § 1104(a)(1)(A).

ERISA and the law of trusts require plan fiduciaries to manage the assets of the Welfare Fund prudently and in the best interests of all beneficiaries. 29 U.S.C. § 1104(a)(1)(B). To comply with these requirements, the Welfare Fund has implemented cost-containment measures including the promulgation of a subrogation provision. This provision requires Beneficiaries who receive recoveries in accident cases to, among other things, reimburse the plan from any recovery in the full amount of accident-related benefits advanced by the Welfare Fund. Since its inception in 1984, the Welfare Fund's subrogation program has achieved recoveries and savings totaling approximately $62.0 million.

Since benefit levels are based on actuarial assumptions which assume a certain level of subrogation recoveries, such recoveries are necessary to provide assets sufficient to fund the benefit levels stated in the various benefit plans offered by the Welfare Fund. Like other large multiemployer plans where contribution rates are set pursuant to collective bargaining agreements and a participation agreement, the Welfare Fund cannot unilaterally increase contribution rates. Thus, if subroga-

tion recoveries are reduced, benefits provided to Beneficiaries will be correspondingly reduced.

The Welfare Fund will be materially and adversely affected by the decision of the Ninth Circuit Court of Appeals in this case. That decision conflicts with decisions of the Seventh, Eighth and Eleventh Circuits which permit the enforcement of subrogation and reimbursement rights in federal courts. *See Administrative Comm. v. Gauf*, 188 F.3d 767 (7th Cir. 1999); *Blue Cross & Blue Shield of Ala. v. Sanders*, 138 F.3d 1347 (11th Cir. 1998); *Southern Council of Indus. Workers v. Ford*, 83 F.3d 966 (8th Cir. 1996). If the Ninth Circuit's decision is allowed to stand, state courts will be the exclusive forum for enforcement of the Welfare Fund's subrogation rights in that Circuit. As a result, and as discussed herein, the Welfare Fund will be able to enforce in piecemeal fashion only, or not at all, its subrogation rights in the Ninth Circuit and other jurisdictions which follow the Ninth Circuit's lead. In contrast, the Welfare Fund will be able to fully enforce its subrogation rights in the Seventh, Eighth and Eleventh Circuits and other jurisdictions. Contrary to the intent of Congress when it passed ERISA, the above split in the Circuits will lead to non-uniform enforcement of the Plan and impose a costly administrative burden on the Plan because the Welfare Fund enforces its subrogation rights in many jurisdictions. In addition, allowing the Ninth Circuit's decision to stand will lead to a reduction of subrogation recoveries and the consequent loss of benefits for Plan Beneficiaries.

Moreover, the decision of the Ninth Circuit will have implications for many other employee benefit plans.

Many multiemployer plans and plans of single employers with nationwide facilities operate in many different states. The Ninth Circuit's decision will cause for these plans the same reduction in subrogation recoveries, increase in administration expenses, and patchwork enforcement of plan terms. The administrative difficulty and added expense caused by such a piecemeal scheme of federal and state regulation of multistate employee benefit plans which Congress rejected when it passed ERISA will thus become a reality for many ERISA plans. *See Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 9-11 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 107-08 (1983).

II. SUMMARY OF THE ARGUMENT

The Welfare Fund seeks to bring to the Court's attention matters not focused on by Petitioner. When it passed ERISA into law, Congress recognized the national interest in employee benefit plans, and the need for exclusive federal regulation of such plans to ensure uniformity in enforcement of plan terms and to eliminate conflicting state and local regulation of such plans. For large multistate plans like the Welfare Fund, the Ninth Circuit's decision makes these laudable goals of ERISA unattainable, creates added administrative expense, and results in reduced subrogation recoveries and consequent reduced benefits for Beneficiaries.

For several reasons, the decision of the Ninth Circuit causes the very harm which ERISA was designed to prevent. First, the Ninth Circuit's decision conflicts with decisions of the Seventh, Eighth and Eleventh Circuits,

causing the unequal, non-uniform enforcement of the Welfare Fund's subrogation provision. Second, the requirement that multistate plans sue in state court to enforce subrogation rights invites state courts to apply a panoply of state laws which diminish or eliminate subrogation rights, further fostering piecemeal enforcement of plan terms.

Moreover, the decision of the Ninth Circuit prevents plan fiduciaries from enforcing the terms of the plan and redressing violations of plan terms as required by ERISA. *See* 29 U.S.C. § 1132(a)(3). In fulfilling these obligations, Congress authorized plan fiduciaries to sue exclusively in federal court to obtain equitable relief under ERISA. 29 U.S.C. §§ 1132(a)(3), 1132(e). In denying the Trustees relief in federal court, the forum which has exclusive jurisdiction over these matters, the Ninth Circuit's decision effectively bars plan fiduciaries from enforcing plan terms as required by ERISA.

III. ARGUMENT: REASONS FOR GRANTING THE WRIT

A. The Decision of the Court of Appeals for the Ninth Circuit Prevents Uniform Administration of Multistate Employee Benefit Plans and Thus Frustrates the Primary Purpose of ERISA.

1. In Promulgating ERISA, Congress Recognized the Importance of Employee Benefit Plans and the Need for Exclusive Federal Regulation of Such Plans to Ensure Uniformity in Enforcement of the Terms of the Plan.

When Congress enacted ERISA in 1974, it recognized that employee benefit plans involved the national public

interest and stressed the importance of the uniform federal regulation of such plans. Congress set forth its findings and declaration of policy in Section 2 of ERISA, which, in part, provides:

> The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations.

29 U.S.C. § 1001(a). As recognized by this Court, ERISA's legislative sponsors emphasized the necessity for uniform federal regulation of not only the substantive provisions, but also of enforcement provisions applicable to such plans:

> "It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law."

Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 99 (1983) (quoting 120 Cong. Rec. 29933 (1974));[2] *see also FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990).

In order to permit plan Trustees to structure plan provisions uniformly for all plan participants, Congress enacted ERISA's preemption provisions. *See* 29 U.S.C. § 1144. To further this same purpose, Congress enacted Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), ERISA's enforcement provision, allowing plans to sue to obtain equitable relief to enforce plan terms and redress violations of plan terms. To ensure uniform enforcement of plan terms, Congress provided that federal district courts shall have exclusive jurisdiction in the above actions. *See* 29 U.S.C. § 1132(e).

Congress rejected amendments to ERISA which would have required ERISA plans to comply with multiple and potentially conflicting state laws which would raise the possibility of "endless litigation" on issues of whether state regulation impinged upon federal regulation. *Shaw*, 463 U.S. at 99 n.20. Thus, after a period of monitoring by the Congressional Pension Task Force and hearings by a House Subcommittee, a report evaluating ERISA's preemption provisions was issued, stating that "'the

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[2] Senator Javits echoed these comments, stating: "'Although the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs.'" *Shaw*, 463 U.S. at 99 n.20 (quoting 120 Cong. Rec. 29942 (1974)).

Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded.'" *Id.* (quoting H.R. Rep. No. 1785, 94th Cong., 2d Sess., at 47 (1977)).

This Court has also on several occasions noted the necessity for exclusive federal regulation of employee benefit plans. In *Shaw*, the Court considered the question of whether New York's Disability Benefits Law was preempted by ERISA. In finding preemption, this Court noted that the obligation of the plans to comply with "the varied and perhaps conflicting" requirements of particular state fair employment laws would make nationwide administration of plans more difficult. 463 U.S. at 105 n.25. The Court emphasized that this sort of interference with the administration of employee benefit plans was exactly what ERISA's comprehensive preemption of state law was designed to minimize. *Id.*

In *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987), this Court recognized that requiring an employer to adopt different payment formulae for employees inside and outside the State would subject the employer to precisely the burden that ERISA preemption was intended to eliminate. *Id.* at 10.[3] This court recognized the diffi-

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[3] Since the laws and regulations applicable to health care benefits vary widely from state to state, the disruptive effect of state regulation is compounded for employee benefit plans, such as the Welfare Fund, which have employees in more than one state. Benefit plans which operate in many states often choose to self-fund benefit payments rather than purchase insurance to cover such benefits. Because state laws vary dramatically, purchasing insurance for plans which operate in

(continued...)

culties which these state rules imposed on plan administrators and stated:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.

Id. at 9.

ERISA's uniform enforcement mechanism complements ERISA's administrative scheme. In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court again confirmed that ERISA was designed to achieve uniformity of deci-

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[3] (...continued)
many states is inefficient, inequitable and increasingly expensive. It was for this reason that Congress passed the preemption clause of ERISA, 29 U.S.C. § 1144. *See Fort Halifax*, 482 U.S. at 10; *see also FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

sion to assist fiduciaries "'to predict the legality of proposed actions without the necessity of reference to varying state laws.'" *Id.* at 56 (quoting H.R. Rep. No. 533, 93rd Cong., 1st Sess., at 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650). This Court noted ERISA's expectation that federal courts would develop federal common law:

> The expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop, indeed, the entire comparison of ERISA's § 502(a) to § 301 of the LMRA, would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws.

Pilot Life, 481 U.S. at 56.

This Court also noted in enacting ERISA, Congress realized that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities:

> A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Fort Halifax, 482 U.S. 1, 11 (1987) (citing H.R. Rep. No. 533, 93rd Cong., 1st Sess., at 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650)).

2. The Decision of the Ninth Circuit Fosters the Very Harm Which Congress Sought to Prevent in Enacting ERISA.

The Ninth Circuit's decision will create the exact patchwork scheme of regulation and enforcement which Congress sought to avoid in enacting ERISA. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). Most obviously, the split in the Circuits which the Ninth Circuit's decision creates will result in the unequal, non-uniform enforcement of the Welfare Fund's subrogation provision. First, denying ERISA plans the right to enforce subrogation rights in federal court under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), may indeed result in the complete abrogation of such rights. Courts in a number of jurisdictions have held that federal courts have exclusive jurisdiction in enforcing such rights and have dismissed lawsuits seeking to enforce these rights. *See*, e.g., *Descant v. Administrators of the Tulane Educ. Fund*, 706 So. 2d 618 (La. Ct. App. 1998); *Jefferson-Pilot Life Ins. Co. v. Krafka*, 57 Cal. Rptr.2d 723 (Cal. Ct. App. 1996). In fact, ERISA itself provides that federal district courts shall have exclusive jurisdiction over enforcement of plan terms. 29 U.S.C. § 1132(e).

Second, the requirement that multistate plans sue in state court to enforce their subrogation provisions invites state courts to apply local laws which diminish subrogation rights and prevents the uniform enforcement of plan terms. *See Ingersoll-Rand*, 498 U.S. at 142. For example, the laws of some states prohibit the enforcement of subrogation rights against uninsured motorist recoveries, recoveries by minors, or recoveries which do not

make a plan participant whole. In other states, the amount of the recovery may be reduced by an award of *pro rata* attorney's fees for a participant's attorney under the common fund doctrine.[4]

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[4] Federal courts are often forced to decide whether to apply state laws that would forbid or limit an ERISA plan's subrogation rights. When confronted with this issue, most federal courts have held that ERISA preempts such laws or that the written language of the plan overrides such laws. *See, e.g., FMC*, 498 U.S. 52 (1990) (ERISA preempts state automobile insurance anti-subrogation law); *Community Ins. Co. v. Richardson*, 172 F.3d 872 (6th Cir. 1999) (ERISA preempts Ohio statute prohibiting reimbursement of medical claims from municipalities); *Electro-Mechanical Corp. v. Ogan*, 9 F.3d 445 (6th Cir. 1993) (ERISA preempts Tennessee statute prohibiting subrogation of health care costs in malpractice cases); *Hampton Indus., Inc. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992) (ERISA preempts North Carolina subrogation statute limiting a self-funded ERISA plan's recovery from third party settlement funds); *Davis v. Line Constr. Benefit Fund*, 589 F. Supp. 146 (W.D. Mo. 1984) (ERISA preempts State law preventing subrogation of an otherwise unassignable personal claim).

Courts have also considered application of the common fund doctrine to ERISA plans. *See, e.g., Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938, 940 (5th Cir. 1998); *United McGill Corp. v. Stinnett*, 154 F.3d 168, 173 (4th Cir. 1998); *Bollman Hat Co. v. Root*, 112 F.3d 113, 118 (3rd Cir. 1997), *cert. denied*, 522 U.S. 952 (1997); *Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997); *Ryan v. Federal Express Corp.*, 78 F.3d 123 (3rd Cir. 1996). In *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 141 (8th Cir. 1997), the court ruled that whether ERISA preempts the common fund doctrine depends on the language of the benefit plan. In *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1296 (7th Cir. 1993), *cert. denied*, 510 U.S. 916 (1993), and

(continued...)

The decision of the Ninth Circuit will create huge burdens on multistate plans and force such plans to rely on myriad rules to enforce subrogation and reimbursement rights. Uniformity in the application of plan terms will cease. The end result of the Ninth Circuit's decision will be the exact patchwork administration of employee benefit plans that Congress sought to avoid in enacting ERISA. *See FMC Corp.*, 463 U.S. at 60; *Fort Halifax*, 482 U.S. at 10-11; *Shaw*, 463 U.S. at 105, n.25.

B. If Allowed to Stand, the Ninth Circuit's Decision Will Diminish a Valuable Cost-Saving Mechanism for Self-Funded Plans.

Many of the cost-containment measures implemented by employee benefit plans transfer actual costs to beneficiaries or restrict the type, length or choice of medical care. Unlike such cost-containment measures, a subrogation provision merely prevents the duplication of benefits by the plan where other coverage exists for a particular injury or illness. In other words, the participant does not recover twice for accident-related medical damages, and the responsibility for the medical care is shifted to the party causing the injury or to the specific-risk insurer who has specifically assumed the kind of risk leading to the injury. Subrogation not only shifts the

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[4] (...continued)
Fields v. Farmers Ins. Co. Inc., 18 F.3d 831, 835-36 (10th Cir. 1994), courts held that the terms of the plan override contrary State laws related to subrogation in Wisconsin and Oklahoma, respectively. *See also* footnote 6, *infra.*, pp. 15-16.

costs of medical care to the responsible party, but also constitutes a valuable cost-savings device. Since the inception of the Welfare Fund's subrogation program, the Welfare Fund has achieved recoveries and subrogation savings totaling approximately $62.0 million.

Under the Ninth Circuit's ruling, employee benefit plans will be ushered to state court to enforce their subrogation rights. As discussed previously, some state courts have held that the federal courts have exclusive jurisdiction over such matters and will, therefore, not entertain such actions. Other states may indeed apply laws which prohibit or diminish the enforcement of subrogation rights. (*See* footnote 4, *supra*, pp. 12-13.) The inevitable result of the Ninth Circuit's ruling will be a loss in subrogation recoveries for the Welfare Fund and other plans, and the consequent loss of benefits for plan participants.[5]

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[5] The Ninth Circuit's decision could lead benefit plans to reconsider their policy of advancing payment for medical bills related to injuries sustained in accidents. If benefit plans cannot enforce their subrogation rights in certain states, and in order to avoid having one employer subsidize the benefits of another employer's employees, plans could add plan provisions to exclude from coverage claims related to accidents in those states where the plan's subrogation provision could not be enforced. Although compensating for lost subrogation recoveries, this added layer of administration would delay payment of a beneficiary's benefits, increase the costs of administering the plan, and lead to the hodge-podge administration of plans which ERISA condemned.

C. The Decision of the Ninth Circuit Prevents the Trustees From Administering the Plan in Accordance with ERISA's Mandate.

ERISA requires that every employee benefit plan be established pursuant to a written instrument and that named fiduciaries control and manage the operation and administration of the Plan. 29 U.S.C. § 1102(a)(1). Congress bestowed upon fiduciaries the power and authority to accomplish these objectives by enacting ERISA's enforcement mechanism. Section 502(e) of ERISA, 29 U.S.C. § 1132(e), affords fiduciaries access to federal courts to enforce plan terms and to redress violations of plan terms. The Ninth Circuit's decision, which denies access to federal court, prevents fiduciaries from administering the Plan as required by ERISA.

Subrogation is not a simple contractual matter between an insured and its insurer where state issues predominate. Subrogation involves enforcing the written terms of the plan under the enforcement mechanism of ERISA. In many instances, the enforcement of subrogation rights by a self-funded employee benefit plan involves the interpretation of a plan's precise subrogation provision—a function best left to the discretion of plan Trustees.[6] Because

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[6] For example, plan fiduciaries must decide whether the written terms of the plan include recoveries from tortfeasors as well as their insurers or recoveries from uninsured motorist coverage. *See Health Cost Controls v. Washington*, 187 F.3d 703, 711-12 (7th Cir. 1999), *cert. denied,* 120 S. Ct. 979 (2000); *Wendy's Int'l, Inc. v. Karsko*, 94 F.3d 1010, 1013 (6th Cir. 1996); *Sunbeam-Oster Co., Inc. v. Whitehurst,* 102 F.3d 1368, 1378 (5th Cir. 1996). Another question of interpretation arises when the written terms of the plan set the priority of allocations

(continued...)

ERISA considerations permeate the enforcement of Plan terms such as subrogation, Congress legislated that federal district courts have exclusive jurisdiction to enforce Plan terms and redress violations of those terms. These are core ERISA issues best left, as Congress intended, to the federal courts. Contrary to the Ninth Circuit's position, the equitable relief which Congress set forth in ERISA is sufficient to accomplish these objectives.[7]

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[6] (...continued)
between the subrogee and subrogor. *See Cagle v. Bruner,* 112 F.3d 1510, 1520-22 (11th Cir. 1997), *reh'g denied,* 124 F.3d 223 (11th Cir. 1997); *Sunbeam-Oster Co.,* 102 F.3d at 1373-76; *Cutting v. Jerome Foods, Inc.,* 993 F.2d 1293 (7th Cir. 1993), *cert. denied,* 510 U.S. 916 (1993). *See also Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) (arbitrary and capricious standard applied when plan gives fiduciary discretionary authority to construe terms of plan).

[7] Ignoring this fact, the Ninth Circuit erred in applying a wrongdoer standard to restitution since restitution redresses any party that would be unjustly enriched by retaining possession of assets whether or not by wrongdoing. *See* 1 *Dan B. Dobbs, Law of Remedies*, § 4.1(2), at 559, § 4.3(2), at 597 (2d ed. 1993). Moreover, the Ninth Circuit's reasoning will have implications beyond the subrogation rights at issue here. For example, under the rationale of the Ninth Circuit, a participant who erroneously pays contributions for ineligible dependents or a plan which erroneously pays a claim cannot bring an action for restitution under ERISA's enforcement mechanism. 29 U.S.C. § 1132(a)(3). In contrast, the Seventh Circuit in *Central States Southeast and Southwest Areas Health and Welfare Fund v. Neurobehavioral Associates,* 53 F.3d 172 (7th Cir. 1995), held that ERISA provided an equitable remedy permitting a plan to recover erroneously made benefit payments.

IV. CONCLUSION

The Ninth Circuit's decision is directly at odds with the goals of Congress in enacting ERISA. If the decision of the Ninth Circuit is permitted to stand, employee benefit plans will be subjected to non-uniform regulations and enforcement. The consequent increased administrative expenses and decreased subrogation recoveries will result in a loss of benefits for plan beneficiaries. Plan fiduciaries will be denied the uniform enforcement mechanism needed to enforce plan terms and redress violations of plan terms. For the reasons stated above, Central States, Southeast and Southwest Areas Health and Welfare Fund respectively requests this Honorable Court to grant the Petition for Writ of *Certiorari*.

March 27, 2000.

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No. 99-1403

In The
Supreme Court of the United States

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA, *et al.*,

Petitioners,

v.

RAYMOND STONE,

Respondent.

On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF OF *AMICUS CURIAE* AND BRIEF OF *AMICUS CURIAE* HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE AN *AMICUS CURIAE* BRIEF

This brief is filed with the consent of Petitioners, and a letter reflecting this consent has been filed with the Clerk of the Court. Respondent withheld consent. As a result, HIAA moves pursuant to Rule 37(2)(b) of the Supreme Court Rules for leave to file this brief.

The Health Insurance Association of America files this Motion For Leave To File An *Amicus Curiae* Brief pursuant to Supreme Court Rule 37(2)(b). Respondent, Raymond Stone, has withheld his consent to the filing of this brief.

There is currently a split among the circuits as to whether an employee benefit plan fiduciary may seek to recoup benefits paid in third-party liability situations under ERISA Section 502(a)(3) when the remedy involves a monetary recovery. This split threatens a critical aspect of cost containment for HIAA's members.

For this reason, HIAA respectfully requests that its Motion For Leave To File *Amicus Curiae* Brief be granted.

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INTEREST OF *AMICUS CURIAE*

The Health Insurance Association of America ("HIAA") presents this brief in support of Cement Masons Health and Welfare Trust Fund's Petition for a Writ of Certiorari.[1]

HIAA is the nation's most prominent trade organization representing the private health care system. HIAA represents the interests of 290 members, which provide health benefits to more than 123 million Americans.

HIAA is filing a brief in this case because the split among the circuits as to whether an employee benefit plan fiduciary can seek to recoup benefit payments in third-party liability situations threatens an important aspect of cost containment for HIAA's members. Third-party recoupment situations arise where employee benefit plan participants are injured, receive benefits, and make another recovery, for the same injuries, from responsible third parties. In these situations, most employee benefit plans, including the Petitioner's plan here, require that the participant reimburse the plan to the extent of benefits paid.

The Ninth Circuit's decision prevents HIAA's members from enforcing these provisions within the Ninth Circuit.

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[1] Counsel for HIAA, Thomas H. Lawrence, certifies pursuant to Supreme Court Rule 37.6 that this brief was not authored in whole or in part by counsel for a party and that no person or entity, other than the *amicus curiae*, its members, or its counsel, made a monetary contribution to the preparation or submission of the brief.

Resolving the split among the circuits and providing guidance to HIAA's membership and other employee benefit plans will provide the plans with direction on how to properly contain cost through the use of subrogation and reimbursement provisions. Failing to resolve the split may result in employee benefit plans–at least in the Ninth Circuit –excluding coverage for injuries caused by third parties.[2]

SUMMARY OF THE ARGUMENT

There is a clear split among the federal courts of appeals on the precise issue presented by this petition – whether enforcing a recoupment provision in an employee benefit plan constitutes "appropriate equitable relief" available under ERISA Section 502(a)(3), 29 U.S.C. § 1132(a)(3). The Seventh, Eighth and Eleventh Circuits hold that claims for relief under reimbursement or subrogation provisions of an employee benefit plan do constitute equitable claims for the purposes of ERISA Section 502(a)(3), regardless of whether a monetary recovery is involved. The Ninth Circuit disagrees, holding that a cause of action under Section 503(a)(3) will not lie whenever the substance of the remedy involves a monetary award.

The holding of the Ninth Circuit is in direct conflict with this Court's holding in *Mertens v. Hewitt Associates*[3]

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[2] While the reported decisions do not reveal that this approach has been widely used, it has been held enforceable. *See The North Carolina Baptist Hospital, Inc. v. Sturgill,* 129 F.3d 1260 (unpublished decision), No. 96-1270, 1997 WL 722776 (4th Cir. Nov. 21, 1997).

[3] 508 U.S. 248 (1993).

and denies employee benefit plans the statutory remedies provided in Section 502(a)(3).

ERISA Section 502(a)(3) provides "[a] civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain *other appropriate equitable relief* (i) to redress such violation or (ii) to enforce any provision of this subchapter." (emphasis added)

In *Mertens*, this Court held that the phrase "other appropriate equitable relief" means those types of relief that were "typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)."[4] The *Mertens* Court did not exclude equitable remedies which would ultimately result in a monetary recovery.

Moreover, the issue presented by this petition threatens a critical aspect of cost containment for many, if not all, employee benefit plans. The Ninth Circuit's decision effectively denies employee benefit plans the right to recoup monies paid on behalf of plan participants in situations where the plan participant recovers money, for the same injuries, from responsible third parties. The Ninth Circuit's decision may result in employee benefit plans–at least plans covering participants residing in the nine states within the Ninth Circuit–excluding coverage for injuries caused by third persons.

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[4] *Id.* at 256.

ARGUMENT

I. The Court should grant the petition to resolve a split among the federal courts of appeals.

A. The federal courts of appeals are split over whether enforcing a recoupment provision in a health plan constitutes "appropriate equitable relief" under ERISA Section 502(a)(3).

In reaching its decision in this case, the Ninth Circuit relied entirely upon its earlier decision in *FMC Medical Plan v. Owens*,[5] which ruled that federal courts do not have subject matter jurisdiction over 29 U.S.C. § 1132(a)(3) claims whenever the substance of the remedy is monetary. The decisions in *Cement Masons* and *Owens* directly conflict with reported cases from the Seventh, Eighth and Eleventh Circuits, which specifically reject the reasoning of *Owens*.[6]

In *Administrative Committee v. Gauf*,[7] the Wal-Mart Associates Health & Welfare Plan (the "Plan") filed suit against Wal-Mart employee Patricia Gauf seeking to compel reimbursement of benefits pursuant to a plan provision requiring reimbursement when employees obtain a third-

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[5] 122 F.3d 1258 (9th Cir. 1997).

[6] *Administrative Committee v. Gauf*, 188 F.3d 767 (7th Cir. 1999); *Blue Cross and Blue Shield of Alabama v. Sanders*, 138 F.3d 1347 (11th Cir. 1998); *Southern Council of Industrial Workers v. Ford*, 83 F.3d 966 (8th Cir. 1996).

[7] 188 F.3d 767 (7th Cir. 1999).

party tort recovery for damages arising out of the medical condition for which the Plan previously paid benefits. As in the present case, the Plan sued under ERISA Section 502(a)(3) to obtain "other appropriate equitable relief . . . to enforce . . . the terms of the Plan."

Gauf argued that the Plan was, in effect, seeking a legal remedy because the ultimate purpose of the suit was to obtain reimbursement of money, and thus, its action could not lie under Section 503(a)(3). The Seventh Circuit rejected this argument, stating:

> Although the pertinent parts of the complaint employ a variety of terms to express the relief requested, we believe that a fair reading of the document in its totality makes clear that the Committee is seeking an equitable remedy against Ms. Gauf to insure her compliance with the terms of the Plan. For example, the complaint requests "specific performance and enforcement" of the contract and an "order enjoining defendant from continuing to violate the terms of the Plan."[8]

In reaching its conclusion, the *Gauf* Court acknowledged the holding of *Owens* but wholly rejected it, stating that "our Circuit has consistently held that a complaint purporting to state a claim for equitable relief

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[8] *Id.* at 770.

under a reimbursement clause in a benefits contract is an equitable claim for purposes of ERISA Section 502(a)(3)."[9]

The Eleventh Circuit also rejected the *Owens* decision in *Blue Cross and Blue Shield of Alabama v. Sanders*.[10] As in *Owens*, *Gauf*, and the present case, the action in *Sanders* arose out of a plan provision permitting the plan to obtain reimbursement in the event the participant obtained a tort recovery against a third party. As in *Gauf*, the defendants relied upon *Owens*' assertion that a reimbursement claim is an action for legal relief unavailable under 29 U.S.C. § 1132(a)(3).

The Eleventh Circuit squarely rejected this argument, stating that:

> *Owens* appears to be based on an unduly narrow reading of *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 113 S. Ct. 2063, 124 L. Ed. 2d 161 (1993). . . . The Court in *Mertens* did not imply that specific performance is unavailable under 29 U.S.C. § 1132(a)(3)(B). Because specific performance is a traditional form of equitable relief, . . . we believe that specific

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[9] 188 F.3d at 771, *citing Harris Trust & Savings Bank v. Provident Life & Accident Ins. Co.*, 57 F.3d 608, 615 (7th Cir. 1995); *Central States, Southeast and Southwest Areas Health and Welfare Fund v. Neurobehavioral Associates, P.A.*, 53 F.3d 172, 173-74 (7th Cir. 1995).

[10] 138 F.3d 1347 (11th Cir. 1998).

performance may be equitable relief available under 29 U.S.C. § 1132(a)(3)(B).[11]

The Eighth Circuit, in *Southern Council of Industrial Workers v. Ford*,[12] upheld the right of a plan administrator to proceed under § 1132(a)(3) to enforce a subrogation provision and a written subrogation agreement. The plan administrator sought to compel a plan participant to reimburse the plan for medical expenses previously advanced out of proceeds gained from settlement of a personal injury claim. Holding that the allegation "that Ford admittedly failed to reimburse is a claim that Ford failed to comply with a term of the Plan," the Court found that the Plan's equitable action for unjust enrichment is permitted under ERISA Section 502(a)(3).[13] This holding, along with the decisions noted above from the Seventh and Eleventh Circuits, is directly at odds with the Ninth Circuit's *Owens* decision.

Other courts likewise have permitted actions for restitution or other equitable relief to proceed under ERISA Section 502(a)(3).[14]

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[11] 138 F.3d at 1352-53, n. 5. *See also In re Unisys Corp. Retiree Medical Benefit ERISA Litigation*, 57 F.3d 1255, 1268-69 (3d Cir. 1995).

[12] 83 F.3d 966 (8th Cir. 1996).

[13] *Id.* at 969.

[14] *See, e.g., Health Cost Controls v. Isbell*, 139 F.3d 1070 (6th Cir. 1997); *LeBlanc v. Cahill*, 153 F.3d 134 (4th Cir. 1998); *Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938 (5th Cir. 1998); *United McGill Corp. v. Stinnett*, 154 F.3d 168 (4th Cir. 1998); *Strom v. Goldman, Sachs & Co.*,

B. The *Cement Masons* decision conflicts with this Court's decision in *Mertens*.

The *Cement Masons* panel relied solely upon *FMC Corp. v. Owens,* which conflicts with this Court's decision in *Mertens*.

In *Mertens*, this Court ruled that the 29 U.S.C. § 1132(a)(3) does not allow a suit by plan participants for money damages against nonfiduciaries who knowingly participate in a fiduciary's breach of fiduciary duty. This Court held that ERISA Section 502(a)(3)'s limitation of remedies to "appropriate equitable relief" means that "money damages" are not recoverable. The Court reasoned that "equitable relief," as used in 29 U.S.C. § 1132(a)(3), means those types of relief that were "typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)."[15]

The Court, in reaching its decision, however, did not bar equitable remedies which would ultimately result in a monetary recovery. The Court did not, for example, state that specific performance,[16] a traditional form of equitable

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202 F.3d 138 (2d Cir. 1999); *Walker v. Rose*, 22 F. Supp. 2d 343 (D.N.J. 1998).

[15] 508 U.S. at 256.

[16] Mandamus–one of the forms of appropriate equitable relief enumerated by the *Mertens* Court–is the equivalent of specific performance. Mandamus is defined as an "extraordinary writ which lies to compel performance of a ministerial act or mandatory duty where there is a clear legal right in plaintiff, a corresponding duty in defendant, and a want of any other appropriate and adequate remedy."

relief,[17] is unavailable under 29 U.S.C. § 1132(a)(3)(B) simply because such a remedy may involve the recovery of money.

In addition, the *Mertens* Court also ruled that "restitution" was among "those categories of relief that were typically available in equity. . . . " Other courts of appeals agree. For example, the Seventh Circuit in *Harris Trust & Sav. Bank v. Provident Life & Accident Ins. Co.*[18] held that an employer's claim for reimbursement of benefits pursuant to an employee benefit plan provision constituted an action for restitution, an equitable remedy available under

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Black's Law Dictionary 663 (6th ed. 1991).

[17] *See Owens-Illinois, Inc. v. Lake Shore Land Co., Inc.*, 610 F.2d 1185, 1189 (3d Cir. 1979) ("An action for specific performance without a claim for damages is purely equitable and historically has always been tried to the court."). Other courts and legal scholars have reached the same conclusion: *In re Unisys Corp. Retiree Med. Ben. ERISA Litigation*, 57 F.3d at 1268-69 (specific performance is an equitable remedy); *Fischer Imaging Corp. v. General Electric Co.*, 187 F.3d 1165, 1172 (10th Cir. 1999) (specific performance is an equitable remedy); *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 660-61 (6th Cir. 1996) (holding that specific performance is an equitable remedy and "[i]t is well-settled that equitable relief includes monetary damages where required to afford complete relief"); Pomeroy, *A TREATISE ON EQUITY JURISPRUDENCE*, § 1401 (5th ed. 1941); Lawrence, *A TREATISE ON THE SUBSTANTIVE LAW OF EQUITY JURISPRUDENCE*, §§ 255, 256 (1929).

[18] 57 F.3d 608, 615-16 (7th Cir. 1995).

§1132(a)(3). The Fourth Circuit, in *LeBlanc v. Cahill*,[19] held that restitution, seeking "to restore the fund to the position it held before," is a category of relief traditionally available in equity, and thus, "falls squarely within the Court's definition of 'appropriate equitable relief' as stated in ERISA Section 502(a)(3)."[20]

Monetary recoveries are commonplace in restitutionary actions and will not transform the nature of the

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[19] 153 F.3d 134, 153 (4th Cir. 1998).

[20] The Ninth Circuit, while recognizing "other appropriate equitable relief" available under § 1132(a)(3) includes restitution, held that "restitution," as used in § 1132(a)(3), means "ill-gotten gains." In other words, a claim for restitution would not lie unless the claimant was seeking to recover gains obtained through fraud or wrongdoing. 197 F.3d at 1005-7, *citing Owens*, 122 F.3d at 1261. The panel concluded that such circumstances did not exist in the present case because the "payment of Ms. Stone's medical bills by appellants was not obtained through fraud or wrongdoing" since "Cement Masons was required under the terms of the Plan to make those payments." *Id.* at 1007. The Ninth Circuit, in reaching this conclusion however, looked only at one side of the coin. While the plan participant's initial receipt of monies paid from the plan for medical expenses does not involve fraud or wrongdoing, the participant's subsequent failure to abide by *his* reciprocal obligation under the plan to reimburse the plan for benefits paid clearly results in "ill-gotten" gain–as defined by the Ninth Circuit–for the participant in the form of double recovery.

remedy sought from an equitable into a legal one as the Ninth Circuit in *Owens* implied.[21]

In addressing this issue of "appropriate equitable relief" under ERISA Section 502(a)(3), this Court in *Mertens* explicitly analogizes the phrase "other appropriate equitable relief" to the similar language of Title VII of the Civil Rights Act of 1964 which includes the term "any other equitable relief the court deems appropriate . . . ."[22] Title VII authorizes equitable relief which includes the payment of money; for example, the Supreme Court has authorized awards of both back pay and front pay (both monetary

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[21] *Schwartz v. Gregory*, 45 F.3d 1017 (6th Cir. 1995); *Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry*, 494 U.S. 558, 570 (1990) (holding that monetary recoveries are considered equitable when "they are restitutionary"); *Health Cost Controls v. Skinner*, 44 F.3d 535, 538 n. 4, 5 and 7 (7th Cir. 1995) ("although [plan administrator] clearly cannot recover compensatory damages under [§ 1132(a)(3)], if it successfully makes out a claim for restitution . . . it may be entitled to monetary relief"); *In re Unisys Corp. Retiree Medical Benefit ERISA Litigation*, 57 F.3d at 1268-69 (equitable relief under Section 1132(a)(3) includes monetary awards typically available in equity, but not compensatory or consequential damages; granting retirees both specific performance of fiduciary's assurances of post-retirement benefits and restitutionary reimbursement of back benefits).

[22] 508 U.S. at 255.

remedies) under Title VII, remedies which constitute "equitable relief."[23]

The *Mertens* panel recognized that "[m]oney damages are, of course, the classic form of legal relief."[24] In *Bowen v. Massachusetts*,[25] a case requiring analysis of the statutory exception in 5 U.S.C.A. § 702 denying district court review jurisdiction in actions against federal agencies seeking "money damages," this Court set forth the basic distinctions between an action for damages and an equitable action for specific relief. In particular, this Court held:

> The term money damages . . . normally refers to a sum of money used as compensatory relief. Damages are given to the plaintiff to substitute for a suffered loss, whereas specific remedies "are not substitute remedies at all, but attempt to give the plaintiff the very thing to which he was entitled." D. Dobbs, Handbook on the Law of Remedies 135 (1973).[26]

Employee benefit plans, in attempting to recoup benefits paid on behalf of a plan participant in third-party

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[23] *See Albemarle Paper Co. v. Moody*, 422 U.S. 405 (1975); *Roush v. KFC Nat'l Management Co.*, 10 F.3d 392, 398 (6th Cir. 1993) (front pay characterized as equitable).

[24] 508 U.S. at 255.

[25] 487 U.S. 879 (1988).

[26] *Id.* at 895, *quoting Maryland Dept. of Human Resources v. Department of Health and Human Services*, 763 F.2d 1411 (D.C. Cir. 1985).

tort recovery situations, are seeking nothing more than specific remedies. The type of relief typically sought by employee benefit plans in such situations includes specific performance, restitution and/or injunctive relief. In pursuing these remedies, plan fiduciaries seek solely to enforce plan provisions and recoup a specific amount of money that has already been paid out. Plan fiduciaries do not seek money damages in an effort to compensate the plan or substitute for payments made in the first instance. Instead, the employee benefit plans are seeking specific relief in these instances which would grant them the very thing to which they are entitled under their plan terms

The Ninth Circuit, relying upon *Owens*, denies employee benefit plans these specific equitable remedies, concluding that "when the substance of the relief is monetary, . . . such a remedy is not available under section 1132(a)(3)."[27] This holding clearly conflicts with this Court's holding in *Mertens* that mandamus, injunction, or specific performance, which clearly encompass monetary relief, are "appropriate equitable relief" within the meaning of 29 U.S.C. § 1132(a)(3).[28]

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[27] 122 F.3d at 1262.

[28] The *Mertens* Court did not hold that "injunction, mandamus, and restitution" are the *only* forms of appropriate equitable relief. On the contrary, the *Mertens* Court reasoned that "equitable relief," as used in 29 U.S.C. § 1132(a)(3), means those types of relief that were "typically available in equity (*such as* injunction, mandamus, and restitution, but not compensatory damages)." 504 U.S. at 256 (emphasis added). The *Mertens* Court was providing examples of equitable relief, not an exhaustive list as the *Owens* panel ruled.

II. This Court should grant the petition to resolve the circuit split concerning an important question of federal law.

The Ninth Circuit's decision effectively denies employee benefit plans the right to enforce subrogation and reimbursement provisions in situations where the ultimate recovery would include money. In so doing, the Ninth Circuit has stripped employee benefit plans of a valid and effective cost containment mechanism.

Employee benefit plans do not, as the Ninth Circuit suggested in *FMC v. Owens*, have the option of pursuing in state court claims to recoup medical expenses. In *Descant v. The Administrators of the Tulane Educ. Fund*,[29] for example, an employee benefit plan paid benefits on behalf of a covered person and moved to intervene in the covered person's state court action in order to enforce the plan's recoupment rights. The Louisiana Court of Appeals affirmed the trial court's decision to dismiss the employee benefit plan's petition in intervention because federal courts have exclusive jurisdiction to determine the recoupment rights of ERISA-covered plans:

> The issue of Canal Barge's right of subrogation is a matter to be decided under the federal ERISA statute, the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1101, *et seq.* Under ERISA, Congress explicitly set forth provisions granting federal district courts exclusive jurisdiction in civil actions brought by fiduciaries intending to enforce the terms of a benefit plan. 29 U.S.C.

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[29] 706 So. 2d 618 (La. Ct. App. 1998)

> § 1132(a)(3)(B)(ii). Accordingly, the federal district court has exclusive subject matter jurisdiction to determine whether Canal Barge is entitled to reimbursement pursuant to a subrogation agreement.[30]

Similarly, in *Jefferson Pilot Life Ins. Co. v. Krafka*,[31] a third-party administrator of an ERISA-covered employee benefit plan sought to recoup benefits paid on behalf of a covered person after the covered person recovered from a third party for the same injuries that had been paid by the plan. The California Court of Appeals reversed the judgment granted in favor of the plan and ordered that the complaint against the plan be dismissed because federal courts have exclusive jurisdiction over recoupment actions brought by ERISA plan fiduciaries:

> . . . [T]he federal courts have exclusive subject matter jurisdiction of civil lawsuits under ERISA, except for actions under Title 29 of the United States Code, § 1132(a)(1)(B) and (a)(7); the state courts have concurrent jurisdiction in matters arising under those sub-divisions. Section 1132(a)(1)(B) and (a)(7) authorize actions, respectively: "by a participant or beneficiary . . . to recover benefits due to him [or her] under the terms of his [or her] plan, to enforce his [or her] rights under the terms of the plan, or to clarify his [or her] rights to future benefits under the terms of the plan" and "by a state to enforce compliance with a qualified medical child support order . . . ."

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30 *Id.* at 627.

31 50 Cal. App. 4th 190 (1996).

> Plaintiff is not a plan participant or beneficiary, nor is it a state. Therefore, plaintiff is not a proper party to bring an action in the state court under ERISA, § 1132(a)(1)(B) or (a)(7). In other words, any action plaintiff may be able to bring under ERISA is not a lawsuit as to which this court can exercise concurrent subject matter jurisdiction. In the absence of subject matter jurisdiction, plaintiff's complaint must be dismissed.[32]

Because of the Ninth Circuit's decision in this case and ERISA's bar against fiduciaries pursuing actions in state court to enforce plan terms, employee benefit plans have no recourse to recoup medical expenses in third-party liability situations except to exclude coverage for such expenses. This Court should grant the Petition and consider this case on the merits.

CONCLUSION

The split among the circuits as to whether an employee benefit plan fiduciary may recoup benefit payments in third-party liability situations under ERISA Section 503(a)(3) threatens an important aspect of cost containment for employee benefit plans. The Ninth Circuit incorrectly interpreted this Court's decision in *Mertens* as barring claims under Section 503(a)(3) whenever the remedy involves a monetary recovery.

This Court should grant Cement Masons Health and Welfare Trust Fund for Northern California's Petition and resolve the split among the circuits, providing guidance on

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[32] *Id.* at 194-95.

how to properly contain cost through the use of subrogation and reimbursement provisions.

Respectfully submitted,

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No. 99-1403

In the Supreme Court of the United States

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA, ET AL., PETITIONERS

v.

RAYMOND STONE

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether a civil action under Section 502(a)(3) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1132(a)(3), to obtain "appropriate equitable relief" may be brought by a plan fiduciary against a plan participant "to redress" a violation of, or "to enforce" a term of, the plan, where the plan term requires the participant to reimburse the plan for medical expenses that the participant recovers from a third-party tortfeasor.

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In the Supreme Court of the United States

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v.

RAYMOND STONE

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's order inviting the Solicitor General to express the views of the United States.

STATEMENT

1. a. Petitioner Cement Masons Health and Welfare Trust Fund for Northern California (Fund) is an employee benefit trust fund subject to the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1101 *et seq.* Pet. 3. The Fund is established pursuant to a declaration of trust executed by certain associations of employers in the construction industry

and representatives of various employee unions. *Ibid.* The Fund is governed by petitioner Board of Trustees, which consists of an equal number of employer and union representatives. The Board has adopted a health and welfare plan that provides, *inter alia*, medical, hospitalization, and other benefits to plan participants and their eligible dependents. *Ibid.*

Respondent, Raymond Stone, is a cement mason and a plan participant. Pet App. B2. On December 19, 1995, respondent's wife was injured by a passing automobile. She was hospitalized and underwent multiple surgical procedures. *Ibid.* On January 23, 1996, she was moved to a rehabilitation hospital to continue her recovery. On January 29, her "gastrostomy tube became dislodged causing a massive infection that eventually led to cardiorespiratory arrest and her death on January 30, 1996." *Id.* at B2-B3.

Respondent's wife was an eligible dependent covered by the plan. Pursuant to its obligations under the plan, the Fund paid $572,325.80 on her behalf for medical expenses from the time of the accident until her death. Pet. App. A3. Pursuant to the express terms of the plan, respondent signed an agreement with the Fund providing that, in the event of an injury for which a third party may be liable, he would diligently pursue any claims for payment of medical expenses against third parties, and that reimbursement would be made to the Fund out of any proceeds received against the third party. *Id.* at A3 & n.2, B3.[1]

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[1] The plan requires that,

> [i]f an eligible individual has an * * * injury * * * for which a third party may be liable or legally responsible * * * the Fund *shall have an automatic lien* upon any recovery against the third party for benefits paid by the Fund * * * and such Eligible Individual *and his Dependents* * * * as a condition

b. The two minor children of respondent witnessed the automobile accident involving their mother. On December 18, 1996, they filed suit, through a guardian ad litem, against the driver of the automobile, seeking damages for negligent infliction of emotional distress caused by witnessing the accident. Pet. App. A4, B3. They settled the suit for $50,000, which was the coverage limit under the driver's insurance policy. *Ibid.*

On January 28, 1997, respondent and his two children filed a wrongful death action against the rehabilitation hospital and certain hospital staff members, among others. The action included a claim of medical negligence by the hospital and staff who allegedly failed to protect respondent's wife against the dislodging of her feeding tube and incorrectly reinstalled the tube, resulting in the fatal infection. Pet. App. A4, B3. On January 21, 1998, respondent dismissed his own claims from the suit. *Ibid.* The children ultimately settled the suit against the hospital for $194,999.99. Br. in Opp. 3.[2]

2. Petitioners brought the instant action against respondent under Section 502(a)(3) of ERISA, 29

> precedent to the entitlement to benefits *shall agree in writing* to reimburse the Fund for any payments made by the Fund * * * such reimbursement to be made out of any proceeds received by way of judgment, settlement or otherwise in connection with or arising out of any claim for or right to damages by such Eligible Individual against the third party, his insurance carrier * * * or any other source of third party recovery.

Pet. 3-4 (emphasis in original) (quoting Article IX, Section 9 of the plan).

[2] Respondent states that "[t]here is no dispute that the law applicable to medical malpractice actions in the State of California limits wrongful death plaintiffs to a total recovery of $250,000 in general damages for loss of love, affection, society, comfort, and solace (Civil Code §3333.2(b))." Br. in Opp. 3.

U.S.C. 1132(a)(3), seeking restitution to the Fund of the medical expenses paid by the Fund for the hospitalization and surgeries, pursuant to the terms of the plan and the reimbursement agreement. Pet. App. A4. Petitioners also sought a judgment declaring the Fund's lien against any recovery from third parties, and an injunction requiring respondent to advise the Fund of the nature and status of any claims against third parties relating to the injuries and death of his wife and preventing him from obstructing the Fund's right to enforce its lien against proceeds recovered by his wife's dependents. *Id.* at A5. Petitioners alleged that respondent attempted to circumvent his obligation under the plan to give priority to claims to recover the medical expenses by allowing his children's claims to exhaust the funds available under the limits in the driver's insurance policy and by dismissing his own claim in the wrongful death suit. *Id.* at A4.

The district court entered summary judgment for respondent. Pet. App. B1-B5. The court ruled that petitioners' claim was for "reimbursement, and such monetary relief is not available under § 1132(a)(3)." *Id.* at B4 (citing *FMC Med. Plan* v. *Owens*, 122 F.3d 1258, 1261 (9th Cir. 1997)). In *Owens*, the district court explained, the Ninth Circuit held that "absent an allegation that plan assets were wrongfully acquired, a claim for monetary relief is a claim for reimbursement" that cannot be brought under Section 502(a)(3). *Ibid.* Because petitioners did not allege that respondent wrongfully procured the payment of benefits at the outset, the court found that it lacked subject matter jurisdiction and dismissed the claim. *Id.* at B5.

3. The court of appeals affirmed. Pet. App. A1-A11. The court acknowledged that injunctive and "other appropriate equitable relief" is available in a suit under

Section 502(a)(3) of ERISA and that such relief includes restitution. Pet. App. A5 (citing *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248 (1993)). The court held, however, that this case does not involve restitution or other equitable relief such as subrogation. *Id.* at A5-A7 & n.5. Rather, the court held that, as in *Owens*, the relief sought here is contract damages or reimbursement pursuant to contract, which, in its view, are not available under Section 502(a)(3). *Id.* at A5-A7. The court noted, but rejected, petitioners' assertion that *Owens* was wrongly decided. *Id.* at A7.

The court of appeals found unpersuasive petitioners' arguments distinguishing *Mertens* and *Owens*. The court rejected petitioners' contention that they are seeking restitution, which this Court recognized as appropriate equitable relief in *Mertens*. See 508 U.S. at 256. The court of appeals was of the view that, under *Mertens*, "restitution, as used in § 1132(a)(3), means 'ill-gotten gains,'" which it construed in *Owens* to mean "money obtained through 'fraud or wrongdoing.'" Pet. App. A7. The court found it undisputed that the medical expenses paid by the Fund in this case were not obtained through fraud or wrongdoing, even if respondent was thereafter obliged to pursue claims against third parties or to reimburse the Fund. *Ibid.*

The court of appeals also declined to distinguish *Owens* on the ground that petitioners sought declaratory and injunctive relief, which, unlike reimbursement, it acknowledged to be appropriate equitable relief under 29 U.S.C. 1132(a)(3). Pet. App. A8-A9. The court dismissed petitioners' request for a declaration of the Fund's lien as "nothing more than a mechanism to enforce, or to obtain the equivalent of, a damage remedy." *Id.* at A8. The court also emphasized that, in this case, "the only existing fund is the $50,000 received

by the two minor children, who have not been made defendants and, in any event, have no obligation whatsoever under the Plan [petitioners] are seeking to enforce." *Ibid.* The court rejected petitioners' request for injunctive relief requiring respondent to apprise the Fund of claims against third parties, because "it is undisputed that [respondent] has not recovered on third-party claims and is not asserting any new third-party claims." *Id.* at A8-A9.

The court of appeals therefore held that the district court correctly applied the substantive holding of *Owens*. The court ruled, however, that rather than dismissing for lack of subject matter jurisdiction, the case should have been dismissed on the merits. The court remanded for entry of such a judgment. Pet. App. A9-A11.

DISCUSSION

The court of appeals erred in holding that a cause of action does not lie under Section 502(a)(3) of ERISA, 29 U.S.C. 1132(a)(3), to enforce a term of an ERISA plan that requires reimbursement of medical expenses to the plan out of funds recovered by a plan participant from a third-party tortfeasor. Section 502(a)(3) authorizes a plan fiduciary to bring a civil action to enjoin any act that violates the terms of a plan and "to obtain other appropriate equitable relief * * * to redress such violations or * * * to enforce * * * the terms of the plan." 29 U.S.C. 1132(a)(3). Appropriate "equitable relief" as used in Section 502(a)(3) means "those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 256 (1993). A plan fiduciary's action for reimbursement of the plan's payment of medical expenses out of a tort recovery obtained by a participant

or beneficiary from a third party constitutes an equitable action to prevent the participant or beneficiary from being unjustly enriched, contrary to the express terms of the plan. The various remedies to prevent unjust enrichment and effectuate reimbursement—*e.g.*, restitution, equitable lien, constructive trust, subrogation, specific performance—are equitable in nature and fall within the scope of relief available under Section 502(a)(3).

The Ninth Circuit's contrary ruling conflicts with decisions of the Seventh, Eighth, and Eleventh Circuits. The Ninth Circuit has reaffirmed the ruling below in two subsequent decisions and declined to consider the issue en banc, thereby demonstrating that the circuit conflict will persist. Petitions for a writ of certiorari to review those two Ninth Circuit decisions are currently pending before this Court as well. *Reynolds Metals Co.* v. *Ellis*, 202 F.3d 1246 (9th Cir. 2000) (affirming district court judgment in light of controlling circuit precedent of *FMC Medical Plan* v. *Owens*, 122 F.3d 1258 (9th Cir. 1997), and also rejecting call for initial hearing en banc), petition for cert. pending, No. 99-1787; *Great-West Life & Annuity Ins. Co.* v. *Knudson*, No. 98-56472, 2000 WL 145374 (9th Cir. Feb. 7, 2000), 208 F.3d 221 (Table), petition for cert. pending, No. 99-1786. The question presented by this case is of substantial importance to the proper enforcement of ERISA because it affects the ability of plan fiduciaries to recoup significant amounts of money on behalf of employee benefit trust funds. Accordingly, review of the issue by this Court is warranted.

We do not believe, however, that the instant case presents the most suitable vehicle for the Court's consideration of the issue, because of several underlying facts that are not typical of this type of suit under

Section 502(a)(3) of ERISA and that may otherwise affect the appropriateness of the equitable relief sought here.[3] In our view, the *Ellis* case presents the best vehicle for addressing the issue presented because it does not appear to involve the sort of complicating factual or procedural issues that may render the instant case a less-than-ideal vehicle for consideration of the issue.[4] Thus, we believe that the Court should grant

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[3] The fact that respondent himself did not recover from any third-party tortfeasor, the failure of petitioners to make respondent's minor children defendants in this action (Pet. App. A8), and the apparent status of the children's tort recoveries (blocked trust accounts and annuities, see Br. in Opp. 3, 14-15), raise issues about the scope of appropriate equitable relief not present in a typical action to enforce a plan reimbursement term. Also, the two recoveries obtained by respondent's children appear to have been for injuries caused to them through negligent infliction of emotional distress based on their witnessing of the accident in which their mother was injured (Pet. App. A4) and through the wrongful death of their mother from medical malpractice, rather than for any medical expenses (most of which were incurred before the alleged malpractice occurred) (*ibid.*). It is unclear to what extent the theory of recovery from the third-party tortfeasor would affect the reimbursement obligation under the plan or the appropriateness of equitable relief. Finally, the scope of the children's reimbursement obligation under the plan even as a general matter is unclear. Compare *id.* at A8 (declaring children have no obligations under the plan) with Pet. 10 n.4 (arguing that children do have certain obligations, as dependents, relating to reimbursement under the plan and the related agreement), Pet. 3-4 (quoting plan document requiring eligible individual's dependents to agree to reimbursement, but specifying that reimbursement is to be made out of proceeds arising out of any "claim for or right to damages by such 'Eligible Individual'"), and Pet. App. A3 n.2 (quoting reimbursement agreement signed by respondent requiring reimbursement to be made out of proceeds arising out of any "claim for or right to damages by the undersigned or his Dependent").

[4] In *Knudson*, the third of the Ninth Circuit cases pending before the Court, the panel decision is unpublished and relies en-

the petition for a writ of certiorari in *Reynolds Metals Co.* v. *Ellis*, No. 99-1787, hold the petition in the instant case pending the decision in *Ellis*, and then dispose of this petition as appropriate in light of the resolution of that case.

1. a. Section 502(a)(3) of ERISA provides, *inter alia*, that a fiduciary of an ERISA-regulated plan may bring a civil action "to enjoin any act or practice which violates * * * the terms of the plan," or "to obtain other appropriate equitable relief * * * to redress such violations or * * * to enforce any * * * terms of the plan." 29 U.S.C. 1132(a)(3). In *Mertens*, 508 U.S. at 256, the Court held that money damages arising from a nonfiduciary's participation in a breach of fiduciary

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tirely on the Ninth Circuit's decisions in *Ellis* and in *FMC Medical Plan* v. *Owens*, 122 F.3d 1258 (1997). See No. 98-56472, 2000 WL 145374 at *1 (208 F.3d 221 (9th Cir. 2000) (Table)). Moreover, the district court in *Knudson* relied on wholly different grounds related to the fact that the status of the plan's lien against the participant's third-party recovery had been determined in a pending state court suit in which the plan had not participated. See 99-1786 Pet. App. at C1-C12; see also 99-1786 Br. in Opp. at 9-10 (noting procedural and factual uniqueness of case).

The petition in *Knudson* also presents an additional question related to the authority of a court to award attorney's fees in the unique situation in which the district court rules on the merits of the case and the court of appeals indicates that dismissal of the case could be based on the merits or on the lack of subject matter jurisdiction, see 99-1786 Pet. at 22-25—a question that is not presented in the instant case or in *Ellis*. Moreover, as the petitioner in *Knudson* points out (99-1786 Pet. at 22-25), the panel ruling in that case on the attorney's fees issue is inconsistent with another recent decision by the Ninth Circuit. Unlike the *Knudson* decision, which is unpublished, that other decision is published, stands as governing circuit precedent on the attorney's fees issue, and is consistent with the other fee decisions cited by the *Knudson* petitioner.

duty are not included within the meaning of "appropriate equitable relief" under Section 502(a)(3) because compensatory money damages are "the classic form of *legal* relief." *Id.* at 255. The Court reasoned that, for purposes of Section 502(a)(3), "equitable relief" means "those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Id.* at 256.

A claim to enforce an express term of a plan requiring reimbursement of medical expenses out of a tort recovery obtained by a plan participant from a third party constitutes an action to obtain "appropriate equitable relief" within the meaning of Section 502(a)(3). Such an action is not one for contract damages, as the court of appeals believed. See Pet. App. A5-A7. When a term of a plan expressly provides that the plan's payment of a participant's medical expenses is conditioned on the participant's reimbursement to the plan out of funds recovered from third-party tortfeasors, a participant is unjustly enriched when he retains the amount recovered from a third party and does not reimburse the plan. An action to enforce such a reimbursement term and to prevent unjust enrichment is properly brought as an equitable action to seek restitution. Restitution is an appropriate equitable remedy to prevent unjust enrichment. Restatement of Restitution § 1, at 19-22 (1936); 1 D. Dobbs, *Law of Remedies* § 4.1(1), at 552, 556 (2d ed. 1993).

The court of appeals' contrary holding—that an action will not lie under Section 502(a)(3) to enforce a term of a plan requiring reimbursement of medical expenses to the plan out of a recovery from a third-party tortfeasor—is inconsistent with the common law of trusts and common-law remedial principles, which this Court has recognized to be incorporated in Section

502(a)(3) of ERISA. See *Harris Trust & Sav. Bank* v. *Salomon Smith Barney, Inc.*, 120 S. Ct. 2180, 2189-2190 (2000). Under established common-law trust principles, trust beneficiaries owe various duties to the trust and to each other. G. Bogert & G. Bogert, *The Law of Trusts and Trustees* § 191, at 478 (rev. 2d ed. 1979) ("Co-beneficiaries are owners of equitable interests in the same res * * * . They are in a fiduciary relation to each other in the sense that one beneficiary may not secretly secure for himself a special advantage in the trust administration."); Restatement (Second) of Trusts §§ 251-255, at 633-642 (1959) (describing duties and liabilities of beneficiary to trust); 3A A. Scott & W. Fratcher, *The Law of Trusts* §§ 250-254, at 358-378 (4th ed. 1988) (same). Thus, at common law, actions could typically be brought in equity to enforce an agreement by a beneficiary to pay money into the trust, *id.* § 252; Restatement (Second) of Trusts, *supra*, § 252, at 635-636; or against a beneficiary for instigating a breach of trust or failing to perform a contract obligation to the trust; or to restore payments improperly made from the trust, G. Bogert & G. Bogert, *supra*, § 191, at 478-485; 3A A. Scott & W. Fratcher, *supra*, §§ 253-254.2, at 368-378; Restatement (Second) of Trusts, *supra*, §§ 253-254, at 636-640; or against a beneficiary for repayment of an advance made from the trust, *id.* § 255, at 640-642. An action for restitution to enforce a term of a plan for reimbursement of medical expenses and to prevent unjust enrichment to a plan participant at the expense of the Fund falls comfortably among such typical equitable claims.[5]

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[5] The fact that enforcement of a reimbursement term would take the form of a judgment requiring the payment of money does not remove such an action from coverage under Section 502(a)(3). An award of monetary relief is not necessarily "legal" relief, as op-

b. The court of appeals erred in holding that, under *Mertens* an action for restitution under Section 502(a)(3) is limited to recovery of "ill-gotten gains," *i.e.* "money obtained through fraud or wrongdoing." Pet. App. A7 (internal quotation marks omitted).[6] The *Mertens* Court referred to the availability of "restitution of ill-gotten plan assets or profits" under Section 502(a)(5) (the provision that authorizes civil actions by the Secretary of Labor to redress statutory violations and that is worded and interpreted similarly to Section 502(a)(3)) as an example of "appropriate equitable relief," but did not purport to limit restitution to such circumstances. 508 U.S. at 260. Indeed, elsewhere in *Mertens* the Court explained, without further limitation, that "equitable relief" under Section 502(a)(3) means "those categories of relief that were typically available in equity (such as injunction, mandamus, and

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posed to equitable relief. For example, the Court has "characterized damages as equitable where they are restitutionary, such as in 'action[s] for disgorgement of improper profits,'" *Chauffeurs Local No. 391* v. *Terry*, 494 U.S. 558, 570 (1990) (quoting *Tull* v. *United States*, 481 U.S. 412, 424 (1987)), and has recognized that a monetary award that is "'incidental to or intertwined with injunctive relief' may be equitable," *id.* at 571 (quoting *Tull*, 481 U.S. at 424); see also *Curtis* v. *Loether*, 415 U.S. 189, 197 (1974); *Porter* v. *Warner Holding Co.*, 328 U.S. 395, 402 (1946); cf. *Harris Trust & Sav. Bank*, *supra*.

[6] The court of appeals emphasized that "[i]t is undisputed in this case that payment of [respondent's] medical bills by [petitioners] was not obtained through fraud or wrongdoing" because petitioners were required under the terms of the plan to make those payments and petitioners are not "challenging their correctness." Pet. App. A7-A8. But the court of appeals did not consider whether a plan participant's retention of payments, in contravention of an express term of a plan requiring the participant to restore the payments to the plan, would mean that the participant is properly considered to be a wrongdoer in the relevant sense.

restitution, but not compensatory damages)." *Id.* at 256 (emphasis omitted).

Under background principles of equity, which the Court in *Mertens* invoked in interpreting ERISA, wrongdoing is not an essential element of a restitution claim. 1 D. Dobbs, *supra*, § 4.1(2), at 559; Restatement (Second) of Contracts § 373, at 209 (1981). The Court recently confirmed in *Harris Trust*, 120 S. Ct. at 2189-2190, that restitution under Section 502(a)(3) is governed by common-law remedial principles, not notions of wrongdoing.[7] The Court there held that the fact that a third party "was not 'the original wrongdoer' does not insulate him from liability for restitution" to a plan of trust property transferred to him in breach of a trustee's fiduciary duty. 120 S. Ct. at 2189-2190. The Court also noted that "the common law of trusts" sets "limits on restitution actions against defendants other than the principal 'wrongdoer,'" allowing restitution from such a third party only if he had actual or constructive knowledge of the circumstances that rendered the transfer unlawful. *Id.* at 2190.[8]

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[7] In *Harris Trust*, the Court held that an action may be brought under Section 502(a)(3) of ERISA to obtain "appropriate equitable relief," including restitution of plan assets, from a nonfiduciary party in interest that participated in a transaction prohibited by Section 406(a) of ERISA, 29 U.S.C. 1106(a).

[8] The Court also noted in *Harris Trust* that another equitable remedy designed to prevent unjust enrichment, *i.e.* a constructive trust, "is based on property, not wrongs." 120 S. Ct. at 2189-2190 (quoting 1 D. Dobbs, *supra*, § 4.3(2), at 597). See note 11, *infra*. In *Owens*, however, the Ninth Circuit erroneously held that a constructive-trust remedy is appropriate only where there is a breach of fiduciary duty and "some form of ill-gotten gain of another's property," such as by "fraud, duress, or unconscionable behavior." 122 F.3d at 1261; see also *Ellis*, 202 F.3d at 1248.

2. In contrast to the Ninth Circuit, several other courts of appeals have recognized that an action to enforce a term of a plan requiring reimbursement of medical expenses out of a recovery from a third-party tortfeasor is properly brought under Section 502(a)(3). Although the courts have applied somewhat different analyses, they have reached the same result.

In *Administrative Committee* v. *Gauf*, 188 F.3d 767 (1999), the Seventh Circuit held that, although the complaint for relief in that case "employ[ed] a variety of terms to express the relief requested," it was clear that the plan fiduciary was "seeking an equitable remedy against [the participant] to ensure her compliance with the terms of the Plan." *Id.* at 770 (citing as examples the complaint's request for "'specific performance and enforcement' of the contract and an 'order enjoining [the participant] from continuing to violate the terms of the plan'"). The court emphasized that it had "consistently * * * held that a complaint purporting to state a claim for equitable relief under a reimbursement clause in a benefits contract is an equitable claim for purposes of ERISA § 502(a)(3)," and the court saw no reason to depart from that precedent. *Id.* at 771 (citing *Harris Trust & Sav. Bank* v. *Provident Life & Accident Ins. Co.*, 57 F.3d 608, 615 (7th Cir. 1995); *Central States, S.E. & S.W. Areas Health & Welfare Fund* v. *Neurobehavioral Assocs.*, 53 F.3d 172, 173-174 (7th Cir. 1995); and *Health Cost Controls* v. *Skinner*, 44 F.3d 535 (7th Cir. 1995)). The court expressly recognized the Ninth Circuit's contrary ruling in *Owens*, but rejected that ruling as inconsistent with its prior case law as well as with decisions of the Eleventh and Eighth Circuits. 188 F.3d at 770-771 (citing *Blue Cross & Blue Shield of Ala.* v. *Sanders*, 138 F.3d 1347 (11th Cir. 1998), and *Southern*

Council of Indus. Workers v. *Ford*, 83 F.3d 966, 969 (8th Cir. 1996) (per curiam)).

In an opinion issued contemporaneously by a different panel of the Seventh Circuit, that court again held that an action by a plan administrator against a plan participant for reimbursement of medical benefits under a term of the plan constitutes an action for appropriate equitable relief under Section 502(a)(3), although in that panel's view the action was best described as an action seeking to impose a constructive trust on the participant's claim to the money, not as an action for restitution, as earlier decisions of that court had suggested. *Health Cost Controls of Ill., Inc.* v. *Washington*, 187 F.3d 703, 710 (7th Cir. 1999) (Posner, C.J.) (discussing, *inter alia*, *Provident Life & Accident Ins. Co.*, 57 F.3d at 615-616, and *Skinner*, 44 F.3d at 537 n.5), cert. denied, 120 S. Ct. 979 (2000).[9] The panel in *Washington*, like the panel in *Gauf*, expressly rejected the Ninth Circuit's holding in *Owens*, specifically disagreeing with the Ninth Circuit's apparent belief "that the imposition of a constructive trust in an ERISA case is permissible only when there has been a breach of trust." *Id.* at 711 (citing *Owens*, 122 F.3d at 1261). The Seventh Circuit panel in *Washington* found no basis for that view "either in ERISA or in the principles of equity." *Ibid.* (noting that, even under ordinary trust law, the historical limitation of a constructive trust as a remedy against only fiduciaries has been abandoned); accord *Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan* v. *Wells*, 213 F.3d 398, 401 (7th Cir. 2000), petition

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[9] The Seventh Circuit reasoned that restitution may be a legal remedy or an equitable remedy, depending on whether it is sought in an action at law or a suit in equity. *Washington*, 187 F.3d at 710.

for cert. pending, No. 00-386.[10] Finally, the Seventh Circuit emphasized in *Washington* that "[a]lternative characterizations of [the plan administrator's] claim (alternative to both restitution and constructive trust)—as seeking to impose an equitable lien on the escrow amount or seeking a mandatory injunction directing [the participant] to sign over her claim to the money—are also permissible, * * * and they reinforce [the] conclusion that [the plan administrator's] claim is securely equitable and so within the jurisdiction conferred on the district court by ERISA." 187 F.3d at 711.

As noted in *Gauf*, the Eleventh Circuit reached the same result in *Sanders*, although based on a somewhat different analysis. The Eleventh Circuit characterized a suit by a plan fiduciary to enforce a reimbursement term as a suit for specific performance, which it found to be an appropriate equitable remedy under Section 502(a)(3). The Eleventh Circuit specifically rejected the Ninth Circuit's ruling in *Owens*, explaining that that decision "appears to be based on an unduly narrow reading of *Mertens*" as limiting "appropriate equitable relief" under Section 502(a)(3) to include *only* an injunction, mandamus, or restitution. *Sanders*, 138 F.3d at 1352 n.5. The Eleventh Circuit concluded that *Mertens* is not so limited and that, because specific performance is a traditional form of equitable relief, it too is available

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[10] The petition filed by the plan in *Wells* does not raise the question presented here. It presents the question whether the common-fund doctrine requires that reimbursement obtained in an action under Section 502(a)(3) be reduced by a proportionate amount of attorney's fees. 00-386 Pet. at i. That attorney's fee issue is different from the one presented in *Great-West Life & Annuity Insurance Co.* v. *Knudson*, petition for cert. pending, No. 99-1786, discussed in note 4, *supra*.

under Section 502(a)(3). *Ibid.* Similarly, in *Ford*, 83 F.3d at 969, the Eighth Circuit held that an action will lie under Section 502(a)(3) for specific performance of a participant's obligation to reimburse a plan under a subrogation clause of a plan.[11]

Thus, other courts of appeals have recognized the validity of actions under Section 502(a)(3) to enforce a reimbursement term of an ERISA plan through a variety of equitable remedies, including restitution, a constructive trust, an equitable lien, and specific performance. In the instant case, the complaint sought restitution as well as injunctive relief and an equitable lien against the third-party recovery. See Pet. App. A4-A5, B2, B4.[12] As noted above (p. 10), restitution is an appropriate remedy sought by petitioners to prevent unjust enrichment. Moreover, in *Harris Trust*, this Court recently recognized that imposition of a constructive trust is an appropriate equitable remedy in an action seeking restitution under Section 502(a)(3).

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[11] In some instances, a term of a plan provides for subrogation instead of, or in addition to, a claim for reimbursement. See *Ford*, 83 F.3d at 969; *Sanders*, 138 F.3d at 1355; 99-1787 (*Ellis*) Pet. at 6-7; see also *FMC Corp.* v. *Holliday*, 498 U.S. 52 (1990) (diversity action seeking judgment declaring self-insured plan's subrogation right; Court reversed summary judgment entered for participant, holding that ERISA preempted application of state antisubrogation statute on which lower courts relied). A claim for reimbursement closely resembles subrogation, which is another means to prevent unjust enrichment. 1 D. Dobbs, *supra*, § 4.3(4), at 605-606. In *Owens*, in addition to rejecting restitution and constructive-trust arguments, the Ninth Circuit rejected a subrogation argument, relying on an unduly narrow view of that remedy as well. See 122 F.3d at 1260.

[12] In *Ellis*, the complaint apparently sought specific performance and restitution. See 99-1787 Pet. at 2; 99-1787 Pet. App. at 13a.

The Court noted that, "[w]henever the legal title to property is obtained through means or under circumstances 'which render it unconscientious for the holder of the legal title to retain and enjoy the beneficial interest, equity impresses a constructive trust on the property thus acquired in favor of the one who is truly and equitably entitled to the same, although he may never, perhaps, have had any legal estate therein.'" 120 S. Ct. at 2189 (quoting *Moore* v. *Crawford*, 130 U.S. 122, 128 (1889), and 2 J. Pomeroy, *Equity Jurisprudence* § 1053, at 628-629 (1886)). A constructive trust is imposed on a particular asset, including a fund of money. 1 D. Dobbs, *supra*, § 4.3(2), at 591. A showing of wrongdoing or dishonorable conduct by the person having legal title to the asset is not required. 5 A. Scott, *supra*, § 462.2, at 313-314; 1 D. Dobbs, *supra*, § 4.3(2), at 597.

Petitioners also properly sought an equitable lien, which is another equitable remedy intended to prevent unjust enrichment. An equitable lien may arise out of an express agreement or may be judicially implied. 1 D. Dobbs, *supra*, § 4.3(3), at 601; G. Bogert & G. Bogert, *supra*, § 32, at 395-401. In the latter situation, it is imposed and operates like a constructive trust—the difference being that the equitable lien provides a security interest in, rather than complete title to, the property in question. 1 D. Dobbs, *supra*, § 4.3(3), at 601; G. Bogert & G. Bogert, *supra*, § 32, at 395-401; Restatement of Restitution, *supra*, § 161, at 18. Like a constructive trust, an equitable lien is not limited to cases of wrongdoing or dishonorable conduct. 1 D. Dobbs, *supra*, § 4.3(3), at 602-603.

3. The question presented by this case is of substantial importance to the proper enforcement of ERISA because it affects the ability of plan fiduciaries to bring actions under Section 502(a)(3) of ERISA to

enforce a term of a plan that allows recoupment of significant amounts of money on behalf of employee benefit trust funds. Indeed, trust law imposes on fiduciaries a duty to preserve trust assets to satisfy future claims, and impartially to account for the interests of all beneficiaries. *Varity Corp.* v. *Howe*, 516 U.S. 489, 514 (1996). Similarly, ERISA requires a fiduciary to discharge his duties with respect to the plan in the interest of all participants and beneficiaries, "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with" Parts I and IV of Title I of the Act. 29 U.S.C. 1104(a)(1)(D). Where a single participant is unjustly enriched at the expense of the plan as a whole by receiving a windfall—through the simultaneous recovery from a third-party tortfeasor and retention of plan payments in violation of a term of the plan requiring reimbursement to the plan in the event of a recovery from a third-party tortfeasor—an action to enforce the reimbursement term does not create "tension between the primary [ERISA] goal of benefitting employees and the subsidiary goal of containing * * * costs." *Mertens*, 508 U.S. at 262-263 (citing *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 515 (1981)). To the contrary, it is consistent with both of those purposes.

Accordingly, in view of the conflict among the circuits and the important and recurring nature of the question presented, further review of this important question is warranted. In light of the atypical facts underlying the instant case (see note 3, *supra*), however, we do not believe that it presents the most suitable vehicle for the Court's consideration of the issue. In our view, *Reynolds Metals Co.* v. *Ellis* presents a better vehicle for addressing the issue presented because it does not

appear to involve the sort of complicating factual or procedural issues that may render the instant case a less-than-ideal vehicle for consideration of the issue.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be held pending action on the petition for a writ of certiorari in *Reynolds Metals Co.* v. *Ellis*, No. 99-1787, and disposed of as appropriate in light of the resolution of that case.

Respectfully submitted.

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IN THE

SUPREME COURT OF THE UNITED STATES

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA and BOARD OF TRUSTEES OF CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA PLAN,

Petitioners,

v.

RAYMOND STONE,

Respondent.

ON PETITION OR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

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STATEMENT OF THE CASE

This action was originally brought by the Cement Masons Health and Welfare Trust Fund for Northern California (hereinafter CMHWT), and the Board of Trustees of the Cement Masons Health and Welfare Trust Fund for Northern California, allegedly to attempt to recover funds advanced to pay the medical expenses of Kimberly Stone, a now deceased eligible dependent under the CHMWT Health Plan.

Appellant is seeking to invoke the terms of their reimbursement agreement and plan from the proceeds of two third party lawsuits filed by the children of the plan participant (Raymond Stone), as a result of the injury and subsequent death of their mother (Kimberly Stone). Raymond Stone was not a plaintiff in either of the underlying third party actions at the time of settlement. Matthew and Haven Stone were the only claimants, and were not named defendants in CMHWT's action that is the subject of this case.

Kimberly Stone was severely injured in an automobile versus pedestrian collision that occurred on December 19, 1995. Haven and Matthew Stone contemporaneously witnessed the the vehicle impact their mother.

Kimberly Stone was taken by ambulance to the University of California Davis Medical Center in Sacramento, California, (hereinafter UCD Medical Center) where she received extended medical care from December 19, 1995 through January 23, 1996. During that hospital admission, she started to regain consciousness and function after multiple surgeries. On January 16, 1996, a gastrostomy tube (stomach tube for feeding) was installed because of Ms. Stone's difficulty with swallowing.

Kimberly Stone was discharged from the UCD Medical Center and transferred to Chico Community Rehabilitation Hospital on January 23, 1996. She remained at Chico Community Rehabilitation Hospital from January 23, 1996 until her death on the morning of January 30, 1996.

On January 29, 1996, Kimberly Stone's gastrostomy tube became displaced, and was subsequently reinstalled by one of the nurses at Chico Community Rehabilitation Hospital. The nurse failed to properly reinstall Ms. Stone's gastrostomy tube, placing it outside of the stomach. Thereafter, feedings were administered to Ms. Stone, liberating feeding materials into her abdominal cavity which caused a severe, overwhelming infection from which she died on January 30, 1996, less than 24 hours after the failure to properly re-install the gastrostomy tube.

Haven and Matthew Stone, then ages 7 and 10, respectively, filed two lawsuits; the first for emotional injuries they sustained from seeing the automobile impact their mother, and the second as a result of the subsequent medical negligence causing their mother's death.

The first action, filed on December 18, 1996, was for negligent infliction of emotional distress pursuant to a bystander theory of liability based on the case of *Dillon v. Legg* (1968) 68 Cal.2d 728 and *Thing v. LaChusa* (1989) 48 Cal.3d 644.

CMHWT did not pay any benefits in connection with or arising out of the children's emotional distress injuries and damages. At the time the children sustained their emotional distress damages, no benefits had been paid for the care and treatment of decedent Kimberly Stone.

The owner/driver of the vehicle that struck Ms. Stone was without assets, but had a policy of automobile insurance covering the vehicle in the amount of $25,000 per person, $50,000 per incident. The only possible plaintiffs in the emotional distress lawsuit, Matthew and Haven Stone, settled their claims against the automobile owner and operator for the policy limits of $50,000. This settlement was consummated by an order approving minor's compromise that was signed by Sacramento Superior Court Judge Cheryl Chun Meegan, on January 14, 1998. Pursuant to court order, after attorney's fees and costs, the funds ($17,855.83 each) were placed in a blocked account, payable on their 18th birthdays.

The second action, filed in Sacramento County Superior Court on January 28, 1997, by Matthew and Haven Stone, and Raymond Stone, was a medical malpractice claim. The suit was based on the displacement and subsequent negligent replacement of Kimberly Stone's gastrostomy tube on January 29, 1996. The negligent replacement of the tube led to infection, respiratory arrest and death of Kimberly Stone on January 30, 1996. Prior to the malpractice, Kimberly Stone was stable and recovering.

There is no dispute that the law applicable to medical malpractice actions in the State of California limits wrongful death plaintiffs to a total recovery of $250,000 in general damages for loss of love, affection, society, comfort, and solace (Civil Code §3333.2(b)). Matthew and Haven Stone settled the medical malpractice case on March 3, 1999, for a payment of $194,999.99. The settlement was consummated by an order approving minor's compromise that was signed by Sacramento Superior Court Judge Roland Candee on April 27, 1999, and pursuant to Court order, these funds were used to purchase annuities for the minors which will pay benefits beginning on each child's 18th birthday.

The respondent in this case, Raymond Stone, is the father of Matthew and Haven Stone. Raymond Stone was only a plaintiff in the malpractice case. He was dismissed on January 22, 1998, because he had been separated from his wife for over one year prior to her death, did not intend to reconcile, and therefore suffered no loss.

Prior to his dismissal as a plaintiff, Raymond Stone was never a Guardian ad Litem for the children in either action because pursuant to Sacramento Superior Court Rules of Court, Chapter 10, Section 10, a potential party plaintiff is not allowed to be a Guardian ad Litem for minors in the same action. [1] After Raymond Stone dismissed his claims, he was appointed Guardian ad Litem.

CMHWT paid medical expenses from December 19, 1995 through January 30, 1996 for Kimberly Stone, totaling $572,325.80. These expenses included payments for her care at UCD Medical Center and at Chico Community Rehabilitation Hospital. Little or none of these medical expenses were paid as

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10.00 Application For Appointment of Guardian Ad Litem.

. . . When application is made for appointment of a guardian ad litem and the nominee for appointment is a plaintiff in the same action with the ward or in some manner was a participant in the transaction or occurrence giving rise to the alleged injury to the ward, the nominee will ordinarily not be appointed unless the application is accompanied by:

(A) A declaration under penalty of perjury setting forth facts establishing that no other parent, relative, or friend can or will accept the appointment of guardian ad litem for the minor in the action; and

(B) A declaration under penalty of perjury by the attorney for the nominee stating that the attorney, having investigated the circumstances, has represented to the nominee and represents to the court that there is no conflict of interest between the nominee and the minor if the nominee is appointed the guardian ad litem.. . . (Emphasis added.) (Sacramento Superior Court Local Rules, Chapter 10.)

a consequence of the January 29, 1996 medical negligence. The only charges that could have been paid by CMHWT from the act of malpractice were those incurred on January 30, 1996, relating to the resuscitation efforts; emergency transfer to Chico Community Hospital; and emergency department charges to diagnose her fatal condition, all of which occurred for approximately 8 hours.

CMHWT filed suit against its insured, Raymond Stone, only (not Haven and/or Matthew) on February 13, 1997. Mr. Stone answered the complaint on June 10, 1997.

On April 15, 1998[2], defendant, now Appellee/Respondent (Raymond Stone), filed a Motion for Summary Judgment, based on lack of jurisdiction, and the fact that equity and the express terms of the plan did not allow for recovery in this case. This matter was heard on May 29, 1998, the Honorable Judge Frank C. Damrell, Jr. presiding. The judge granted the summary judgment, and ordered CMHWT's claim dismissed.

The trial court's Memorandum and Order, filed on June 2, 1998, stated: "Stone argues that plaintiffs' suit seeks reimbursement, not restitution within the meaning of §1132(a)(3), and that the court lacks subject matter jurisdiction over plaintiff's claim for reimbursement. The court agrees. Stone's motion for summary judgment is granted." (Memorandum and Order, p. 2, 11. 5-7.)

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A typographical error exists in 9th Circuit Respondent's brief indicating April 15, 1997.

The basis for the trial court's ruling was the decision of the Ninth Circuit in *FMC Medical Plan v. Owens,* 122 F.3d 1258, 1261 (9th Cir. 1997), holding that *Mertens v. Hewitt Assoc.,* 508 U.S., 248, 113 S.Ct. 2063 (1993), precluded any action under §1132(a)(3) of ERISA for "monetary relief". (Memorandum and Order p. 2.)

The U.S. Court of Appeals for the Ninth Circuit affirmed, in part, finding that *FMC Medical Plan, supra,* is "legally indistinguishable" from the present case and compels dismissal. Cement Masons Health and Welfare Trust Fund v. Stone, 197 F.3d 1003, at p. 1006 (1999).

The panel reversed the trial court on one point regarding the dismissal of the action for lack of jurisdiction. The panel held that jurisdiction did in fact exist, but that ERISA provided no remedy and that the dismissal should have been on the merits. The case was remanded to the U.S. District Court with instructions to dismiss the case on the merits (Id. at p.1007-08).

The circuit panel found that no claim of restitution would lie against Raymond Stone, stating at page 1007:

> "Appellants also make two arguments why *Mertens* and *Owens* do not control this case. Appellants first contend that they seek 'restitution' which they characterize as an equitable remedy. However, restitution, as used in §1132(a)(3) means 'ill-gotten gains'. *Mertens*, 508 U.S. at 260, and we have construed ill-gotten gains to mean money obtained through 'fraud or wrongdoing', *Owens*, 122 F.3d at 1261. It is undisputed in this case that payment of Mrs. Stone's medical bills by

appellants was not obtained through fraud or wrongdoing. Cement Masons was required under the terms of the Plan to make those payments, and Cement Masons is not challenging their correctness. Rather, appellants contend that Mr. Stone is obliged to reimburse Cement Masons for those payments out of money obtained from third parties, and to pursue claims that might result in obtaining additional money from third parties in the future. Even if Mr. Stone has some obligation to pursue such claims and to reimburse Cement Masons (a question we do not decide), that obligation does not make money previously paid by Cement Masons 'ill-gotten gains' subject to restitution within the meaning of §1132(a)(3)."

Further, the Court stated at page 1008:

"Two of the three remedies appellants seek depend on the propriety of enforcing the lien. Enforcement of the lien, however, is nothing more than a mechanism to enforce or to obtain the equivalent of a damage remedy. Further, on the facts of this case, the only existing fund is the $50,000 received by the two minor children, who have not been made defendants and, in any event, have no obligation whatsoever under the Plan appellants are seeking to enforce. The third remedy appellants seek is an injunction that would require Mr. Stone to keep them informed of claims against third parties. However, it is undisputed that Mr. Stone has not recovered on third-party claims and is not asserting any new third-party claims."

The above heart of the decision of the 9th Circuit panel was totally misrepresented by appellants' brief at page 9, wherein appellants construed the underlying decision as follows:

> "In affirming the trial court, the circuit panel rejected the argument that a clam of restitution would lie against Raymond Stone; the panel held that an action in restitution is only appropriate where the claimant is seeking to recapture 'ill-gotten gains'. 197 F.3d at 1006-07, citing *Owens* 122 F.3d at 1261. The panel stated that "we have construed ill-gotten gains to mean money obtained through 'fraud or wrongdoing ..."' and found that Stone's refusal to honor his reimbursement agreement and plan reimbursement requirements did not cause his 'gain' of over half a million dollars to be 'ill-gotten.' 197 F.3d at 1007."

The implication made by appellants is that the 9th Circuit cited *Owens, supra*, in describing "ill-gotten gains", when in fact the Court was citing *Mertens, supra*. Further, the appellants imply that the 9th Circuit felt that Mr. Stone received a gain of over a half a million dollars, which was not found to be ill-gotten. As can be seen from the 9th Circuit opinion, this is a misrepresentation of the findings of the Court.

Further, appellants state at pp. 9 and 10:

> "Finally, the panel ruled that the only fund at issue was $50,000 recovered by the Stones' two minor children who 'have no obligation whatsoever under the plan appellants are seeking to enforce." [4] 197 F.3d at 1007.

The above fails to point out, as was noted in the 9th Circuit's decision, that appellants did not seek to sue the two minor children, but sued only Mr. Stone who received none of the funds derived from either lawsuit.

Appellants allege in their application for Writ, page 10, that:

> "The panel in Stone acknowledged the fiduciaries' contention that 'Mr. Stone attempted to circumvent his obligation by allowing his children to exhaust the [insurance] policy limits with their claims ... [and] Mr. Stone dismissed his own claims in [a] second lawsuit to prevent the fund from sharing in any recovery resulting from the wrongful death claim.' [5] 197 F.3d at 1005. But the panel failed to discuss the implications of these undisputed points in the record."

Appellants misstate the opinion of the panel, which actually said, at 197 F.3d 1005:

> "**According to appellants** Mr. Stone attempted to circumvent his obligations by allowing his children to exhaust the driver's policy limits with their claim for negligent infliction of emotional distress. **Appellants contended further** that Mr. Stone dismissed his own claims in the second lawsuit to prevent the fund from sharing in any recovery resulting from the wrongful death claim." [Emphasis added.]

This is a far cry from the statement of appellants that the panel acknowledged their contention.

SUMMARY OF ARGUMENT

Defendant and Respondent/Appellee Raymond Stone contends the case of *FMC Medical Plan v. Owens* (9th Cir., 1997) 122 F.3d 1258 establishes that CMHWT's lawsuit is meritless and should be dismissed. CMHWT is seeking straight contractual monetary recovery for medical expenses they had to legitimately pay under its health plan. This is not equitable relief, and therefore is prohibited under the provisions of ERISA.

It appears that CMHWT believes that all types of causes of action are available for monetary damage under the construction that common law doctrines may be adopted pursuant to ERISA. This is contrary to the express terms of ERISA and would open the door for unlimited litigation not only by ERISA plan fiduciaries, but by participants and beneficiaries under the plan. Thus, by this construction, any cause of action resulting in monetary damages that could be construed to be related to, or involved with, an equitable right could result in damage verdicts never anticipated by the legislative mandates of ERISA statutes.

CMHWT is also not entitled to reimbursement based on the express language of the plan. The plan only allows CMHWT to seek reimbursement for medical expenses paid arising from a third party's negligence. In this case, CMHWT did not pay any medical expenses relating to the children's emotional distress claims. These injuries and damages to the children accrued at the time of impact in the auto accident. This was before CMHWT paid any medical expenses.

Further, the only medical expenses paid by CMHWT that relate to medical negligence, if any, were those paid after the act of malpractice on January 30, 1996. These expenses, if paid, would have related to the efforts undertaken to resuscitate; emergently transfer her to the emergency department of Chico Community Hospital; and evaluate her condition to render a diagnosis. (It is believed no such charges were ever made because of the hospital's negligence.) CMHWT did not pay any medical expenses or benefits in connection with or arising out of any injury, illness, disease or other condition caused by third party wrongdoer (medical malpractice), other than those possibly incurred over a few hours on January 30, 1996.

REASONS THE PETITION SHOULD NOT BE GRANTED

A. The Facts Of This Case Are Particularly Unique And Will Never Again Be Seen In A Case Involving ERISA Issues.

There were two distinct lawsuits based on two distinct negligent acts. Neither of the two lawsuits trigger repayment of benefits under the express terms of the health plain.

Appellants further contend that Mr. Stone attempted to circumvent his obligation to Cement Masons by allowing his children to exhaust insurance policy limits, and contend that the 9th Circuit panel acknowledged such a contention in their opinion. (Appellant's Application for Writ of Certiorari, p. 10.) Further, in footnote 5 on page 10, appellants state: "In fact, it appears that Mr. Stone arranged for a third party to serve as Guardian ad Litem for the children, precisely to avoid the terms of the plan, and the reimbursement agreement."

These are false allegations. The Superior Court in and for the County of Sacramento, State of California, Local Rule, Chapter 10, Section 10, establishes that a potential party to an action should not be appointed as Guardian ad Litem, since a potential conflict of interest exists. Mary Kay Carlton was named as the independent person to be the Guardian ad Litem, in order to comply with the local court rules. The panel did not acknowledge that Mr. Stone attempted to circumvent his obligation. The facts are that the Court stated on page 1005 as follows:

> "According to appellants, Mr. Stone attempted to circumvent his obligation by allowing his children to exhaust the driver's policy limits with their claims for negligent infliction of emotional distress. Appellants contend, further, that Mr. Stone dismissed his own claims in the second lawsuit to prevent the fund from sharing in any recovery resulting from the wrongful claim." [Emphasis added.]

It is noteworthy that appellants are misrepresenting their contentions as the findings of the 9th Circuit Court of Appeai. This is obviously false and contrary to the language of the opinion (Id. at p. 1005).

Thus, there was no wrongful conduct engaged in by Mr. Stone. It should be further pointed out, as was stated in the Respondent's brief before the 9th Circuit, at page 8, Mr. Stone had been separated from his wife for in excess of a year prior to the accident in question, and it was therefore deemed inappropriate to sue for a loss that could not be proven because there was no true marital relationship in existence. Further, Mr. Stone was not present at the time the injury occurred to his wife on December 19, 1995, or January 29, 1996, and therefore

could state no cause of action for emotional distress under California law.

All of the above issues are unique and will not be seen in other ERISA cases. Therefore, the petitioners writ should be rejected.

B. The Facts And Circumstances Of This Case Would Require The United States Supreme Court To Interpret The Effect Of California Civil Code §3333.2 Limiting Damages To $250,000 In Medical Malpractice Cases And Decide Issues of Intra-Family Allocation.

The maximum damages that can be recovered for general damages in medical negligence cases are limited by statute in the State of California (Civil Code §3333.2(b)). The ability to recover damages on behalf of the minor plaintiffs are thereby reduced in that said minor plaintiffs did not have the opportunity to be fully compensated for the loss of their mother because it arose from a negligent act of a healthcare provider. This would impact the ability of any ERISA plan to recover advanced expenses. Since the minors cannot collect the true value of their loss, the equity of allowing an ERISA plan to collect 100% of their payments, even if it exceeds the amount recoverable under California law, should be considered.

Further, under the facts of this case, no damages could be sought for the expenditures made by CMHWT. The medical expenses were not incurred as a result of the negligent conduct of the hospital since they were incurred prior to the time of the negligent act which resulted in the death of Kimberly Stone. Therefore, the only recovery available to the minor children was for their loss of comfort and society due to the death of their

mother as opposed to the medical expenses that were incurred in her care and treatment. In this case, the wrongful act of the hospital did not cause the expenditure of $572,325.80, and the minor children could not recover those expenses in their wrongful death action.

Further, the damages sustained by the minor children as a result of negligent infliction of emotional distress theories involved no payment of medical expenses. The appellants contend that the father should have sued the driver of the vehicle that struck his wife for her wrongful death. However, since the policy of insurance available under said cause of action was only a $25/50,000, this would have generated only one $25,000 payment to be spilt among the minors and Mr. Stone. Appellants contend that an election should have been made between the welfare of Mr. Stone's children (in suing for independent causes of action they possessed for watching their mother be struck by a car), and Mr. Stone suing the driver for her medical expenses, which could only have been sued for by decedent (which obviously could not be done because she was deceased).

These equitable defenses would all be available in any action for "other appropriate equitable relief "pursuant to 29 USC §1132(a)(3). Therefore, this case presents truly unique and different facts than any other case that could be brought before the Supreme Court involving these issues, and is not appropriate for review.

C. There Was No Unjust Enrichment.

As a result of the lawsuit filed herein, a total of $244,999.99 was recovered for the minor children from all sources. Said funds were placed in blocked, interest bearing trust accounts, and used to purchase annuities for the benefit of

the minor children. Appellants contend that unjust enrichment would exist if the $572,325.80 was not paid to CMHWT. It is obvious that the amount of damages that would normally have been recoverable in a case such as this are not available based on a limitation of damages discussed supra, under California Civil Code §3333.2, limiting general damages to $250,000. Can it be said that the total sum of $244,999.99 fully compensates two young children for the loss of their mother? Unjust enrichment means a double recovery. There was no recovery whatsoever for the medical expenses that were paid herein. Therefore, there was no unjust enrichment when there has been no double recovery.

D. The Opinion In This Case Does Not Leave The Petitioners Without Remedies To Enforce Written Agreements With Their Participants.

The unique facts of this case will never be seen again. This case, decided on its own facts, has many equitable defenses that would have been applied in the underlying action, had the action not been dismissed. It would amount to a useless act to overturn the opinion of the 9th Circuit and remand this case to the district court for hearing on the facts that would allow this case to be defended on equitable grounds and plan participation wherein no recovery would be obtained by CMHWT.

RESPONSE TO AMICUS BRIEF FILED BY CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND

All of the above arguments regarding the uniqueness and equitable defenses that apply in this case also apply to the Amicus brief filed by Central States, Southeast and Southwest

Areas Health and Welfare Fund (CSSSAHWF). The argument made by CSSSAHWF also alleges that prohibiting the health plan from collecting paid medical benefits to their participants would be the death knell for their benefit program. However, a closer inspection of the argument reveals the fallacy of their contention.

On page 2, CSSSAHWF claims that they have 300,000 beneficiaries. They further indicate that their welfare fund has been in existence since 1984, and the fund's subrogation program has achieved recoveries and savings totaling approximately $62 Million. They go on to state that if the subrogation recoveries are reduced, the benefits provided to beneficiaries will be correspondingly reduced.

If one divides $62 Million (recovered and saved) by 16 years (the length of the plan's existence), and then divides the yearly amount of $3,875,000 by 300,000 (participants), the reduced benefits would be $12.92 per year per participant, or $1.08 per month reduction. Obviously, this is not a significant reduction and shows the lack of merit in the health plan's argument. Further, no discussion is set forth in the Amicus brief as to how many cases are not pursued as a result of the plan's claim for reimbursement, as opposed to claims that would be pursued in the absence of reimbursement. This clearly effects the numbers stated, and the welfare of those persons who could have brought a lawsuit and did not.

CONCLUSION

For the reasons set forth herein, based on the unique circumstances set forth in the underlying action, and its relationship to the laws of the State of California, this case should not be accepted for Writ of Certiorari on the basis that it would not be a definitive ruling with regard to other potentially litigatible cases.

Respectfully submitted,

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